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ABSTRACT

Presented is a summary of a 5 week program of intensive demonstration therapy conducted with three adult severe stutterers by three master clinicians aided by seven consultants and 15 participating fellows. A main purpose of the institute is said to have been the improvement of student clinicians through demonstration of intensive therapy techniques to 15 supervisors of clinical training in various institutions. A therapy plan and other information is given for each of the three clients. Therapy is described week by week for each client individually as well as in group activities. Explained are therapy goals such as increased self understanding, the breaking of habit patterns, "fluent stuttering", the reduction of speech avoidance behaviors, and analysis by the client of stuttering blocks. Significant changes in the attitudes, understanding, and behavior of the three stutterers is reported. Also noted is the reaction of the clinical fellows that the experience at the institute would greatly effect their work with stutterers and student clinicians. (DB)

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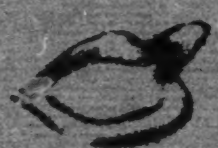
Stuttering

AN ACCOUNT OF INTENSIVE DEMONSTRATION THERAPY

SPEECH FOUNDATION OF AMERICA



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Stuttering

AN ACCOUNT OF INTENSIVE DEMONSTRATION THERAPY

At the Speech Foundation Institute in Stuttering Therapy
Northern Michigan University, Marquette, Michigan
July 1-August 3, 1971

C. Woodruff Starkweather

SPEECH FOUNDATION OF AMERICA
Publication No. 8

Speech Foundation of America
152 Lombardy Road
Memphis, Tennessee

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Explanation

Last year the Speech Foundation of America decided to conduct a five-week program of intensive demonstration therapy with a small number of severe stutterers at Northern Michigan University in Marquette, Michigan. The Foundation felt that a number of purposes could be served by such an Institute.

First, they thought they could improve the training of student clinicians by inviting, as participating fellows, fifteen supervisors of clinical training from various institutions over the country. These clinical fellows would observe and participate in the intensive therapy performed by three master clinicians, who were known to be successful with stutterers.

Second, through close observation via videotape and discussion among the fellows, it was hoped that new insights and a deeper understanding of the process of therapy would be achieved and that these "results" would be passed on to the speech pathology profession. Third, by providing intensive therapy of high quality, the Foundation would be able to offer a limited number of severe stutterers an excellent opportunity to solve their communicative problems.

In addition to using the best master clinicians it could find, the Foundation felt that the quality of therapy could be enhanced further by the participation of a number of consultants. So seven consultants were chosen who were men of considerable eminence in this field. These were to spend at least two days at the project site and provide constructive suggestions about the therapy in progress. It was not, however, one of the purposes of the Institute to compare different types of therapy or different approaches to therapy.

The responsibility for selecting the personnel including the editor, was undertaken by a committee of the Foundation. The responsibility for selecting the stutterers was delegated to the master clinicians. All these arrangements were completed and the participants assembled in Marquette, Michigan, on July 1, 1971.

It was one of the most intensive and concentrated demonstration therapy projects ever attempted. The three master clinicians worked with three severe stutterers in rooms with one-way mirrors for four full weeks under the continuous observation of fifteen experienced clinicians, working in five-man teams, with a large part of the therapy being videotaped for all to observe and criticize.

The names of the participants (excepting the stutterers) are listed on the following pages.

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For the Speech Foundation of America
Memphis, Tennessee

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Author's Preface

Growth is usually too slow a process to see, but when something speeds it up there is excitement, fascination, and satisfaction in watching it. And therapeutic growth is the most exciting kind to watch. As Editor for the Speech Foundation of America Institute in Stuttering Therapy, and as author of this report, I had a chance to watch this kind of growth in three clients from a vantage point that was most unusual.

What I saw was a series of changes in the attitudes, understanding, and behavior of three stutterers, and I have tried to tell the story of those changes in this report, but the *way* I saw it was unique in my experience. Although I spent a fair amount of time watching therapy and participated in as many discussions as possible, most of my information came from reports (logs, we called them) written by the participants. Whenever one of the participants saw or talked with one of the clients for any length of time, he reported the event to me in writing. Whoever wrote the log would of course leave out details he thought were unimportant, expand others, interpret ambiguous events, make inferences about the client, and judge the effectiveness of therapy. Some strove for objectivity, even reporting conversations word for word; others spent a lot of time carefully thinking out and writing up subjective analyses. I encouraged this kind of individuality as much as possible, so, at the end, I had six different points of view on each client, plus my own observations. Although born of expediency, this method of information-gathering balanced fact with interpretation, and detail with abstraction in such a way that I was able to see therapeutic growth take place more dramatically than I would have thought possible. I hope, in telling the story of the Institute, I have expressed some of the excitement I felt in watching it.

Clearly, I would not have been able to write this story without the cooperation, talent, and effort of all the participants in the Institute. Their contribution was so great that I can think of no adequate way to express my gratitude for their help. At the same time, I do not want to leave the impression that they are responsible for the content of this report. As author, the choice of details to report, the judgments, and the interpretations are my own, and the responsibility for any errors is also entirely mine. I also want to thank particularly Charles Van Riper, whose understanding, serenity, and humor were influences I felt while composing this tale; Malcolm Fraser, who was kind enough to ask me to write it; and Dick Boehmler, Lon Emerick, and Paul Czuchna, who showed both talent and courage in posing for their clinical portraits.

September 1971
C.W.S.

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Operation

THE FIRST FEW DAYS

There were two days of preliminary activities, followed by a weekend before the Institute went into full swing. During much of this time, the Fellows were coping with housing problems or trying desperately to find out where they were supposed to be. They also heard a lecture by Dr. Van Riper on the purpose, procedures, and anticipated problems of the Institute.

Housing

The housing consisted mostly of small motel cabins equipped with housekeeping facilities. In the center of a rough circle of these cabins was an 8 x 45 mobile home, and it was in this trailer that the three clients lived, surrounded by the Fellows, two of the Master Clinicians (The third lived at home in Marquette), and the Editor. Whether the clients perceived this arrangement as threatening or protective was not sure, but they were certainly the focus of attention.

The atmosphere of The Compound, as it came to be called, contributed in no small way to the atmosphere of the Institute generally and to the quality of the experience the Fellows had. For one thing, it was a rare night when they slept well. The beds were filled with the sand that permeated everything, coming from nowhere, even in the cabins of those who never went to the beach – a geological version of spontaneous generation.

Then there were parties, and the cabins were so close that a party on the far perimeter of the circle was enjoyed to its full extent by those trying to sleep at the other end. It felt luxurious to lie in bed staring at the ceiling and realize that without even the effort of stirring from bed, it was possible to enjoy the social pleasures of one's neighbors.

Some of the participants brought their families, so the compound also contained a number of wives, two husbands, a substantial number of children, from toddlers to teen-agers, and assorted pets. It was anything but a homogeneous group. The participants themselves varied widely in age, education, rank, and geographical location. Not least important, they represented a wide diversity of training, theoretical orientation, and approach to therapy.

The Schedule

This diverse group of human beings encountered its first obstacle to a unity of direction in The Schedule. The Schedule demanded first that the entire group meet each morning in a review session at 8:30 a.m. to review the activities of the preceding afternoon. This period lasted for up to an hour and often contained the most intensive comment and creative planning of the day. In these sessions, each Master Clinician reported on the preceding afternoon's activities, and the group commented on the achievement of goals or on their own interactions with the clients. Some of the morning review session time was also spent considering the three clients as a group, and occasionally there were suggestions about changes in procedure or format.

Immediately after the morning review session the participants split into teams, and each team met with its Master Clinician in a therapy planning session. The purpose of this session was to plan the therapeutic activities of the day ahead. About 45 minutes was spent in this session, so that the first two morning activities concluded at 10:00.

Between 10:00 am and 12:00 noon several different types of activities took place. The major purpose of the morning therapy sessions was to make a videotape of therapy with each of the stutterers to be played back later in the same day. However, since only one videotape unit was available, two of the teams did nonvideotaped therapy while the third team used the unit. Therapy time before noon was therefore broken up into three 40 minute segments, and for a given client only one of those segments was videotaped while the other two were not. At 12 o'clock everyone broke for lunch.

In the afternoon the videotapes that had been made in the morning were shown to the two teams that had not been involved in making them. In other words, teams two and three watched team one's tape and so forth. Each showing was introduced by one representative from the team that had made the tape to inform the viewing group about the goals and purposes of the session. After the showing, the entire group discussed what had transpired. The discussion was supposed to take place along certain lines: the purpose was generally to gain insight into and to increase our understanding of the process of therapy as performed by these three Clinicians. Consequently, the emphasis was more on analysis and dissection than on criticism. Occasionally, of course, it was impossible not to be critical, so to forestall depression and ultimate suicide the Clinician under scrutiny was absent when his tape was discussed. These discussion sessions were valuable experiences for those who took part in

them. In the beginning, when therapy was just underway, they were very exciting. As the first massive changes in the Clients' attitudes took place, the excitement of therapeutic success was unrestrainable. Later, when some of the Clinicians were slogging through the necessarily tedious details of therapy, the most exciting moment of discussion was the suggestion to go home.

Meanwhile, back at the clinic, the Clients were still in therapy, and the gang of rustlers was hidden in the sycamore tree. Each of the Clients received two hours of individual therapy between 1:30 and 4:30, and all three stutterers came together for an hour of group therapy in the middle of the afternoon. The group therapy session was handled for an entire week by one Master Clinician and then the next week by another.

In the evening, activities were informal, if not rowdy, except when the entire group of participants met with the Consultants in extended discussion of the Institute, of stuttering in general, or of particular problems encountered with the Clients.

Also during those first few days the first Consultant, Dr. Van Riper, told the Fellows what it was hoped the Institute would achieve, warned of the pitfalls, and provided general guidance. The Fellows were told to be analytical but not critical, involved but not dominating.

THE CLIENTS

More by accident than by design, but consistent with the heterogeneous group of participants, the clients were as unlike each other as three stutterers could be. Allen Williams was a twenty-two-year-old sophomore majoring in Business at a northwestern college, having completed his service in the army. His major interests were combat sports, judo and karate and auto mechanics. Joseph Du Pre was nineteen years old and unemployed. He occasionally lifted weights and seemed to be interested in popular music. He planned on going to cooking school, but he didn't really think he would succeed. Robert Roth was a seventeen-year-old high school student from Brooklyn, New York. He was interested in animals and planned to become a veterinarian. All three were severe stutterers. In one way or another, all of them had given up. Allen had withdrawn from all forms of communication in which he felt inadequate to communicate. Since his communication was inadequate in many situations he spent much of his time alone or in the presence of others but with his thoughts far away. Joe slouched through life like a sad faced rag doll, rarely speaking, resigned to defeat before entering any communicative situation. Bob wheedled, coaxed, and played on the sym-

pathies of others in order to achieve his needs without communication.

Joseph Du Pre

HISTORY. After the first interview, Joe's Clinician noted that he was good looking and shy, but limp and dejected – a sad sack. He was "tight and low key" and "laconic." His speech was described as follows in the Clinician's report.

> Joe's stuttering is severe, at least 6.5 on the Iowa Severity Scale and very complex. He has long fixations, a glazed look comes over his eyes and a distinct tremor spreads over the right side of his face and lower jaw during a block. When he really gets stuck he makes a tongue sucking noise, a sort of "tsk" to release the fixation; one time during the end of the interview he made a spitting motion and sound as he attempted to release a fixed posture on a plosive.

In a second interview, he was given some paper and pencil tests, videotaped, placed in trial therapy, and given a psychological evaluation. At the end of the day the Clinician wrote down the following comments:

> Joe's major concern seems to be to project a real cool image . . . based upon what the undergraduates term a 1957 "greaser" model. His only diversions seem to be weight lifting and illicit beer drinking parties with several buddies. He never mentioned his younger brothers. His mother seems to support him and intervene when his father complains about Joe's unemployment and chronic stuttering.
>
> Joe seems to have a distorted relationship with his father. He said that his "old Man" griped because he had to drive Joe to the airport early that morning. Joe added that his father "doesn't give a damn," that he never has time for him and takes off every weekend to go fishing and hunting with his cronies. When I mentioned some of the testing we would be doing, Joe wanted to know if they would reveal that he had been slapped often by his father when he stuttered; he was concerned that he may have been psychologically damaged by his father's abuse.
>
> Joe is a very severe stutterer. His blocks are long, agonizing monsters, mainly tonic but with some clonic aspects. They last as long as 30 seconds and may be as brief as 3 seconds (average, about 8 seconds). He closes off the airway at the tongue tip, lips, and larynx. During a fixation of an articulatory posture that lasts longer than 5 seconds, a rapid tremor (which seems to be initiated in the lips) spreads over the right side of his face and down to the musculature of the neck. He uses avoidances and starters (well, um, let's see) and postponement devices; sometimes he abandons the speech attempt altogether or seduces the listener into playing twenty-questions to complete the communication. His escape and release devices are especially punishing; tongue sucking and biting, spitting motion (dry and wet!) and gross body movements. The total impres-

sion is immobility; when he stutters, he breaks eye contact, his eyes glaze a bit, he fixates on a posture and pushes hard; when he runs out of breath, he will try again. There may or there may not be sound, usually not, associated with these prolonged struggles.

After a third interview, and a brief visit with Joe's parents, the Clinician dictated the following report:

Well, Joe's low-key demeanor masks a need to communicate as big as all outdoors. He keeps the lid screwed down tight so the steam won't escape but also, and perhaps more important, to prevent any intrusion. He seems afraid to give and take – at least with me. He plays the role of Great Stone Face. However, I did see a few chinks today: he greeted me with genuine warmth and a firm handshake; he said he did not like being so quiet – after a long silent period – that it embarrassed him but he does have difficulty talking with older people; he talked "freely" about his father; and, when I was leaving, he again offered his hand and indicated he was looking forward to seeing me soon. Anyway, here are some observations made today:

Joe is stuttering as severely as ever. We stopped in a local hangout for coffee, and a buddy accosted Joe suggesting that they go fishing. Joe tried to say that he couldn't and initiated a tremor that radiated all the way out to his index finger (which was pointing at me.)

He wants desperately to get a job that will free him from his father's domination. Mr. Du Pre, according to Joe's report, derides him continually about his hair, his bad driving, his unemployed status, and most of all his stuttering. "He is always in a hurry," said Joe, "And whenever I do try to talk with him he tells me to 'spit it out' or 'Why can't you learn to talk?' or 'Quit that goddamn stuttering!' " Consequently, Joe and his father have very little communication.

Mrs. Du Pre told me some interesting items about Joe's background: he began to talk at the "normal age" but used single words only; after a bout of pneumonia at age eighteen months, he returned home from the hospital repeating whole words. This rapidly regressed to fractured syllables and sounds and eventually the monstrous silent struggles he now manifests. She added that Joe's teachers always complained about his penmanship: he writes in a jerky fashion producing wavy lines much like an old man writes. She added that he has tremors of both arms and hands, most often the right. Joe agreed that he does have tremors, intermittently, but often at a state of rest. Mrs. Du Pre added that these tremors were very manifest when Joe was in high school and doing poorly academically.

Can Joe do the job? He seems like such a mess, frankly. We did some trial therapy, helping him to integrate the sounds and syllables into words. We showed him how to start the airflow, movement, and sound at the same time, shaping for the vowel and prolonging it slightly. He caught on quickly and said several words in this fashion. At any rate, I think he smells the cheese at the end of the maze, he seems to have an idea of where we intend to go and the path we are going to follow. We shall see what we shall see.

THERAPY PLAN. The Clinician established six long range goals which he hoped Joe would achieve during the four weeks of therapy ahead. The first was for Joe to develop an understanding of what he does when he stutters. This goal was to be achieved first by teaching Joe something about stuttering in general through bibliotherapy, discussion, and by observing other stutterers and nonstutterers. In order to find some specific things about his stuttering, Joe was to be instructed to duplicate his stuttering pattern and describe it to others. As part of this goal an attempt would be made to discover escape devices, triggers, loci of tension, closures, avoidances, disguise behaviors, and fears related to listeners, content, and words. Descriptive language was to be used.

A second long term goal was to teach Joe that he could break up the habit pattern, that he could change his pattern of stuttering and the way he talks. To achieve this goal, he would learn how to add, drop, and vary portions of his stuttering pattern. He would also be taught slow motion stuttering and tremor analysis. An analysis of starting postures and of the patterns of sound and airflow would be made. Light easy contacts would be taught. His distracting mannerisms would be reduced and eliminated if possible. He would also be taught the techniques of cancellation and pullout.

A third major goal was the achievement of an objective attitude about his stuttering and some measure of desensitization to it and to the fears and frustration related to it. To accomplish this goal Joe would be taught to seek out his fears and identify them. An attempt would be made to teach him to tolerate his stuttering and the frustration associated with it. He was to be taught, via negative practice, how to do both easy and hard stuttering voluntarily. An attempt would be made to reduce his avoidance behavior by looking at them closely, by identifying them, and by varying them. And his eye contact was to be improved. The plan was also to have him verbalize his fears and frustrations, to have him test reality situations where those fears and frustrations might not be valid, to subject him to some communicative stress and teach him to withstand it, perhaps to desensitize him systematically, and to use implosive therapy if desired.

A fourth goal was to teach him "fluent stuttering." To achieve this goal, he would engage in negative practice, learn preparatory sets, and learn how to make strong deliberate movements in articulating syllables and words. He would be taught voluntary prolongations, emphasizing the consonant vowel transitions. Some of the therapy would be stuttering in unison, and an attempt would be made to reduce his expectancy of stuttering.

A fifth goal was the acquisition of patterns for normal speech. To achieve this goal, Joe would be placed on delayed auditory feed-

back so that he could try to beat the machine. He would also engage in shadowing and choral speaking, he would make speeches with stage diction and exaggerated articulation; he would indulge in whispered speech, and speech with the electrolarynx; he would speak under masking noise. He would also be taught some of the basic arithmetic skills which the occupational training report indicated were in need of improvement. An attempt would be made to have him acquire a self-image as a fluent stutterer. And there would be reading, paraphrasing, and self-talk.

The sixth goal was to have all of the newly acquired behaviors learned to the extent that they would serve in a number of different stressful situations. First of all it was important that Joe be able to speak with the new pattern under variations of time pressure, audience size, listener reaction, and propositionality. Furthermore he had to be able to use the newly acquired patterns with authority figures, while being assertive, and under varying degrees of background noise. Also, he had to be able to withstand a certain amount of torture from his listeners and still be able to maintain his new patterns.

Allen Williams

Allen contacted his Clinician in response to a newspaper advertisement, stating that he had a severe stuttering problem and that he was interested in the project. He was seen for an evaluation accompanied by his father. Neither Allen nor his father could recall his early speech and language development, although they both remembered Allen's stuttering by the time he was nine years old. Mr. Williams was asked about Allen's early experience in school, and he reported that Allen used to "stop and start over" as an aid for stuttering. Allen remembered only that he used to "just keep trying." He sat towards the back of the room in school, but most of the teachers still required him to recite. He recalled stuttering "three-quarters of the time" from fifth to eighth grade.

Allen was living at home with his father and his brother. His parents had been divorced following a separation in 1959. The housekeeping was done by the three men. Mr. Williams owned and operated a sign company, in which Allen worked both before and after his stretch in the service.

COMMUNICATIVE BEHAVIOR. Allen's voice quality, pitch level, and general vocal expressiveness were within normal limits for his age and sex. His articulation was normal, and his language skills seemed to be at least average. The only areas of significant deviation noted were in fluency and verbal patterns associated with fluency

breakdown. The articulation was occasionally substandard, with "dee" in the initial position and some slighting of the articulation of "ell" in medial position. These errors are not as frequent during fluent speech and may have been associated with the fluency disorder.

Allen's speech was characterized by frequent dysfluencies in both, oral reading and spontaneous speech. He read at 90 words per minute with 32 dysfluencies per 100 words and spoke spontaneously with 52 dysfluencies per 100 words.

Typically, Allen's stuttering showed syllable repetitions, prolongations, and broken words. When he blocked, Allen stopped the articulatory process abruptly, and restarted the sequence by repeating previously fluent phrases and words. The rate of the sound repetition was sometimes slow, suggesting conscious control, but most frequently the rate was rapid, as in hypertension tremors.

When Allen read and tried to stutter as little as possible, he read at a slower rate with a stacatto-like rhythm. During this reading he produced dysfluency at the rate of 8 per 100 words, all of them simpler in form than those he had shown previously; specifically, there were no dysfluencies within dysfluencies.

In the discussions that followed this reading, however, his dysfluency rate increased immediately to 52 per 100 words, a rate which was typical of his spontaneous speech during the intake interview. The Clinician summarized this initial evaluation as follows:

> Allen seems to be an adequately adjusted young man who is solving, or has solved, most of the personal, social, and educational problems typical of his culture, except for a significant communication problem characterized by advanced stuttering behavior.
>
> Specifically, his speech is characterized by a high frequency of dysfluencies, a large portion of which are probably avoidance devices developed to circumvent a breakdown in the articulatory sequencing process. The source of the breakdown is not completely diagnosed, but undoubtedly includes a large anxiety-associated hypertension factor. Other sources of breakdown cannot yet be ruled out but will be easier to identify as the avoidance patterns are modified and anxiety is reduced.

Following the evaluation, Allen was asked to write his autobiography.

THERAPY PLAN. Allen's Clinician felt that therapy, as a general principle, should be the responsibility of the client rather than of the clinician. Consistent with this approach, the therapy consisted of a number of procedures designed to teach Allen the skills he would require to be his own clinician. The general goals of therapy were consequently based on the assumption that Allen would identify

those goals as appropriate for him, since the Clinician would not state the goals in a directive manner. Given this assumption, the general goals were as follows:

1. Reduce speech "avoidance behaviors" to less than one per one hundred words.
2. Reduce tension and avoidance in response to real or anticipated dysfluencies to the point that no increase in tension is observable in at least 90 per cent of the communication situations Allen encounters.
3. Achieve a self-concept as a speaker such that communication is viewed positively in social, educational, and vocational situations.
4. Reduce fluency breakdowns due to tension to less than one per one hundred words.
5. Increase Allen's understanding of self, communication behavior, and therapy to the point where he can establish, achieve, and maintain goals for effective communication.

As a general strategy, the first step of Allen's therapy, and one that it was suspected would continue throughout therapy, was for Allen to develop an understanding of his communicative behavior and how to modify it. After the first step, the second step was to reduce avoidance patterns such as word and phrase repetitions and interjections. The third step was desensitization to dysfluncies. And the fourth step was an examination of the remaining fluency breakdowns and the development of appropriate remedial procedures.

Robert Roth

Bob Roth lived at home with his mother, who had been employed for the past eight years as a saleswoman. Bob's father had died from a heart attack the preceding year at the age of 59. A maternal grandmother occupied the downstairs apartment of her two family house with Bob and his mother living upstairs.

SPEECH BEHAVIOR. Bob's most severe blocks were 5-20 seconds long and consisted of rapid (three per second) repetitions, accompanied by rising vocal pitch, contracted and raised eyebrows, and glassy eyes. He used nearly every device known to stutterers to avoid those blocks and when they occurred anyway he recoiled from them with horror, backing up, changing the subject, moving ballistically, anything to escape. These severe blocks occurred only at key points in the utterance, primarily points of high information loading and were consequently infrequent. But he also had many small, brief repetitions that he had long since stopped noticing.

During the reading of Fairbank's "Rainbow" passage, however, Bob exhibited almost normal fluency. His airflow was normal, and the effortless prolongations of the initial phonemes on the words "many," "high," "two," and "no" were short, loose, and forward flowing. He commented that, "That's the first time I ever read anything so long without stuttering so bad." He seemed pleased and happy with himself. When asked if it surprised him, he said, "Yes, but I read it over first."

Bob had developed certain tricks to disguise his stuttering behavior – primarily bodily movements to time the initiation of feared words, such as moving back in a chair at the "right" moment. In order to release himself from blocks he would hit his hand on a table with force or just try harder (struggle). In order to avoid feared words he used synonyms, circumlocutions, and telegraphic speech. To postpone speech attempts he used accessory vocalizations such as "ah," "like," and "I mean," repeated preceding words, and paused in order to change the phrase. Starter behaviors to initiate feared words included starter sounds, words, and phrases; body jerks, eye blinks and other sudden movements; foot tapping; recoil with running starts; suddenly increased or decreased tension; and sudden changes in the intensity of voice.

To reduce the fear of stuttering, Bob distracted himself with movements, by visualizing the spelling of the word he was trying to say, or by whispering the word silently. Bob would also release himself from a block by stopping and trying again or by stopping and using some distraction and then trying again; by continuing with increased force or tension in the speech muscles; and by changing the pitch of his voice. He felt that when others completed his uttererances "it makes it easier" for him and that "he doesn't mind." He would even wait and use others' completions when he was having a lot of difficulty.

THERAPY PLAN. Bob's Clinician felt that as a general goal Bob should try to come to an understanding of what he was doing when he stuttered. He should be able to go back after having had a block and put it back together again. To achieve this general goal Bob was to analyze his stuttering blocks and whittle them down into their component parts so as to understand how the moment of stuttering was put together. This procedure was to be followed for his postponement and avoidance behaviors, for his timers, for his release devices, and all of his stuttering behaviors down to the tremor, which would be the last behavior to be worked on. No more specific procedures were planned because the Clinician felt that such specific planning imposed a rigidity on the therapeutic situation that was incompatible with the unpredictability of human behavior. As it turned out, however, even this plan was too specific.

The Four Weeks of Therapy

THE FIRST WEEK

Joe Du Pre

Before the formal therapy was undertaken, Joe was given the following description of what was to follow:

> Intensive Therapy Program: Joe
>
> The basic plan of therapy will consist of the following: whenever you stutter with any force or struggle or whenever avoidance or delaying a word is evident, you must stop, write the word on a piece of paper or card and then go through this routine: 1. integrate the sound (air-voice-proper articulatory posture); 2. integrate the syllable, shaping for the second sound before saying the first; 3. say the word *slowly* but with strong deliberate movements.
>
> If you fail at any of these you must do the whole sequence until you are successful and *you are not to continue until these three steps are done right.* We will refuse to listen to you, we shall turn away or put our fingers in our ears. We must be consistent in preventing the old stuttering from leading to communication.
>
> Note: (1) the only exception to this policy is when you stutter smoothly and easily on a word. We will reward these. (2) You are not to complete the word on which you start stuttering but to stop immediately. This is to be a searching and putting together procedure.
>
> 1. We will begin most of the sessions by having you tell us what the previous therapist did; tell us how it went. We will devise many ways to do the same thing, namely, put speech back together again.
> 2. We will have you read word lists, phrases, passages, etc. Practice saying them in the old way and the new smooth, slow motion stuttering, changing back and forth; go faster and louder. Then whisper the words to get a good feel of how they are said.
> 3. Enter at least one feared situation involving authority, time pressure, telephone, involved explanation, requesting favors, speaking to strangers, etc., after you get the idea of what we are doing. You must plan exactly the first sentence you will say and then analyze your performance after.
> 4. Spend about five to ten minutes of each period reading aloud, talk about yourself, your memories, your ideas, etc. When you do this you must fill your speech full of tiny, new, easy stutterings. The therapists should speak to you in the same way.
> 5. Part of the day will be spent (the afternoon) on trying to beat the DAF machine or any other method to block out sight and sound so that you can feel what you do when you stutter.

Joe's Clinician also gave detailed assignments to his team of five Fellows. These assignments were worked out in great detail, accounting for most of the time during the day. Hardly a minute was lost; even the coffee breaks were programmed for therapy. Team members were also given general instructions about how to behave during the evening when talking with Joe.

A few hints of trouble to come cropped up on that first day. In a memo to his team on Tuesday, Joe's Clinician noted the following.:

> The picture I got was of a confused kid, perhaps seeing Bob and Allen as having great understanding and confidence to handle their speech. Low man on the totem pole. He kept talking about failure. I tried to make him see that an image of failure will fulfill his expectations. Thinking and remembering are tough for him and we have, frankly, been wordy and abstract, I fear.

The first morning of therapy had been complicated. Some baselines were obtained in which Joe read aloud and spoke spontaneously while his moments of stuttering were counted. Then, as therapy was directly introduced in the videotaped session, the Clinician worked toward three goals simultaneously: identification, variation, and desensitization. The idea was to get Joe to identify the particular kinds of stuttering that occurred in his own speech. Specifically, these behaviors consisted of repetitions, tremors, fixations, prolongations, silences, vocal fry, and four starting devices – a "tisking" sound, a spitting sound, retrials, and a prolonged "ummmmmm." It was felt that the simple confrontation of these auditory components of stuttering would produce some degree of desensitization. Joe was able to identify whole word repetitions as stuttering and also prolongations.

A close analysis of this tape session was not possible because of equipment failure, but generally it was felt that Joe had not participated as fully as he might. His answers were laconic, and he only spoke when spoken to. There was some evidence of tension and a tendency not to approach and face some of his more objectionable behaviors such as the spitting.

Joe also participated in two nonvideotaped sessions that morning. In the first one he was trained in some techniques for identifying tension and relaxation modeled after Jacobsen. Joe was able to do this for the most part, and he was given some assignments to do similar exercises during the day.

In the second nonvideotaped session, the Clinician concentrated on training him to identify and vary the visual and auditory aspects of his stuttering. At first, he trained Joe in observation generally, asking him to describe an object or a person. He then asked him to describe his stuttering. At the end of the session Joe said it was hard to remember all the terms he had heard.

During the break between the morning and afternoon sessions, Joe went with one of the team members to lift weights and continue therapy. The team member noted that Joe seemed more relaxed outside the clinic.

The first session of the afternoon was informal. Joe and a team member reviewed the therapy of that morning, and Joe seemed pleased with the success he had had using the prolongation technique. At the end of the session he was introduced to delayed auditory feedback, and its effect on the speech of stutterers and nonstutterers was demonstrated to him. He was quite impressed with the effect it had on his speech, and the team member pointed out that he could successfully modify his speech in the direction of greater fluency.

In the second afternoon session, Joe was asked to listen to and scrutinize the speech of the other two stutterers and try to identify the auditory aspects of their stuttering. He was partially correct but not very explicit. He was also asked to produce some slow deliberate examples of the spitting behavior in order to bring it vividly to a conscious level. He was then asked to use the spitting behavior nine times voluntarily in the group therapy session later that afternoon.

When the afternoon sessions were over Joe disappeared from sight for a few hours. He turned up later that night, lonely and depressed, at a team member's cabin. He talked about his childhood, his attitudes toward the Institute, and his speech goals. The team member thought he showed much tension at times. Bob came in during this conversation, filled with confidence, more fluent than anyone had seen him yet, and he dominated much of the conversation. When he left Joe seemed relieved. It was evident that things were happening in the trailer, but we couldn't be sure what they were.

On Tuesday morning, Joe's Clinician and his team planned to redo some of the preceding day's therapy, partly because the equipment had failed to operate properly and partly as a review for the client. So again Joe was asked to vary his spitting behavior, to spit voluntarily, and to mass the behavior. A new note was added, however, in that the Clinician planned to "do something wild, a surprise." In part, this last activity was designed to help Joe develop a sense of humor, but it was also intended to desensitize him to the reaction others might have to his deviant speech behavior.

Joe was able to recall, label, and demonstrate four of the six previously identified auditory components of his stuttering. And when his Clinician demonstrated the remaining two he was able to label them correctly. Some voluntary spitting then followed, but before they got very far the Clinician deviated from the therapy plan, noting that Joe seemed to have tightened up and suggested that they

"do some voluntary stuttering together." This was done for a while with the Clinician doing a substantial amount of voluntary stuttering too. They then went back to the identification and close analysis of the spitting behavior and continued this task until the end of the session. Joe was also given an assignment to voluntarily "tisk" eleven times during the afternoon group session. Another assignment that had been given to him earlier was apparently misunderstood and not carried out.

When the tape was shown that afternoon, the Fellows suggested, as alternative methods for accomplishing the same goal, that Joe could have been trained to identify his behaviors from a videotaped recording of them or by establishing and administering an operant conditioning program with reinforcement contingent upon correct identification of the behaviors. The advantage of being able to describe his successfulness in precise terms with the operant technique was noted.

During the first nonvideotaped session that morning Joe was trained further in the identification of general body movements and of areas of tension in his stuttering pattern. He was also trained to vary the pattern and to tolerate a pause so that he would have time to alter his articulatory postures. Joe reported that he had been trying to identify tensions in faked blocks on his name, and it appeared that he had been successful in doing so. Having identified the sequence of tensions for the first sound of his name, the team member proceeded to have Joe stutter voluntarily on each part of his [redacted] and finally while saying the total sequence. He was successful in trying out these tasks.

In the other nonvideotaped session that morning, one of the team members worked with Joe to try and heighten his awareness of the "tisking" behavior. Joe was first asked to produce the tisk voluntarily in the context in which he would ordinarily use it. A distinction was made between situations in which it might be appropriate to make a tisking sound and ones in which the tisk was a starting device related to stuttering. He was then asked to speak at some length without using either the tisking or the spitting. He did this without making any errors. Glottal fry, silent blocks, and hard contacts, however, were noted.

In a second portion of this same morning session Joe was assigned to interview his Clinician as if the Clinician were a job applicant. Joe was given several minutes to plan what he would say and then the Clinician entered the room. As he did this he mimicked Joe's behavior, his limp gait, his dejected posture, and his passive and defeated attitude. He actually crawled through the door, sat in the chair, meekly shook hands with the "interviewer," and stuttered the

way Joe did, using his spitting and tisking behaviors. Joe laughed out loud, and it was the first time the Fellows had seen him laugh.

The Clinician and Joe then discussed what had happened. They talked about the differences and similarities between emotional feelings and their physical manifestations. During the discussion of stress, Joe identified certain stressful situations that he reacted to the most: asking questions of strangers, carrying the therapy ideas to nonclinical situations, time pressure, and phone calls.

They then performed a second role-playing situation, in which one of the team members played a strict authority figure and Joe played the role of a job applicant. As soon as the team member took an authoritarian tone, Joe showed marked postural changes, decreased his vocal intensity, and reverted to silent blocks, hard contacts, and vocal fry. He showed every evidence of being extremely anxious. Afterwards he and the Clinician discussed what had transpired.

During the afternoon therapy session, Joe reviewed his morning assignment of faking the sequence of tensions for specific sounds, pausing for three seconds, and then moving forward through the word. He then reviewed the therapy procedures for the entire day in his own words and was able to feed back all of the information he had acquired. He had some difficulty remembering the videotaped session, but with some prompting he recalled the role-playing and the interview. A discussion followed of how other people react to stuttering, after which Joe rank-ordered the following situations according to the amount of anxiety with which he would react to them: (1) making a speech in front of a group of people, (2) asking to read in front of his high school classmates, (3) asking his father for the car, (4) asking his father for his allowance, (5) job interviews, (6) asking for something in a grocery store, (7) making a telephone call, (8) meeting strangers, and (9) people in a hurry.

More voluntary stuttering was done in an informal situation while having a coke at the Student Center, and Joe seemed to carry out this assignment without difficulty.

That evening Joe went to his Clinician's house for dinner after having attempted an assignment in the afternoon. He had not been able to carry out the assignment, partially because unforeseen events took place, but partially also because it was difficult for him. After the aborted assignment, Joe said he was afraid he was going to "mess up" the Institute. That morning he had received his check for the week's expenses, and he said that he was going to fail and not "earn his keep." His Clinician counseled him that in this context he would be successful if he did the best he was able to do, but the feelings of failure were too deep to be wiped out that easily. He also began to show again that he was confused, that too much was going on and

that there was too much for him to remember. Everything was too verbal. There was too much information. At one point he said he was so confused he didn't even know what was confusing him. His Clinician said "What is stuttering for you?" He answered, "I break up a word." The Clinician suggested dropping all the assignments, all the new terms, and just try to "put the word back together again."

Looking at this moment of crisis in retrospect, it seemed that receiving the check had triggered sudden, massive feelings of unworthiness, accentuating as it did the need for Joe to perform at his best. He knew he was not performing as well as his roommates and consequently was filled with doubts, fears, and a sense that he had, and would, fail. The team members who were recording his therapy sessions had not seen it this way. For the most part, they felt that he was moving forward, even though he had not always been totally successful in carrying out the tasks. Three elements seemed to be at work: first the tasks were too difficult for him – they were too verbal, too complicated, and they seemed always to be testing his intelligence. Second, one of his roommates in the trailer was experiencing sudden fluency and may have been gloating about his success. Third, he was physically tired. He had had a full day of therapy, with hardly a break, and then he had gone to his Clinician's house for dinner, and the highly verbal and therapeutically oriented environment continued. It was just too much.

The next day Joe's therapy proceeded in much the same manner, since it was too late to change plans and the full impact of the evening before had not quite been realized. In the videotaped session, the plan was for Joe to stop whenever he stuttered with any force or struggle or whenever he used an avoidance behavior and write down the word on a piece of paper and then go through the following routine: (1) integrate the sound with proper air, voice, and articulation, (2) integrate the syllable, shaping the second sound before saying the first, and (3) say the word slowly but with strong deliberate movements. If he failed at any one of these he had to do the whole sequence until he was successful, and he was not to continue until these three steps were done right. He was told that the team members would refuse to listen to him; they would turn away or put their fingers in their ears. When he stuttered smoothly and easily on a word, however, he would be rewarded. Joe had difficulty in carrying out these tasks. Every time he blocked he would begin to struggle with the word or the sound. The next task was for Joe to look at a picture for a minute and then tell his Clinician what was in the picture after it had been taken away. Here again the task was difficult, requiring both cognitive and verbal skills, and Joe didn't do very well. He was then asked to read a short paragraph and to

describe its content to the Clinician. He was successful at keeping his speech forward-moving, but not at relating the content of the paragraph.

After the Fellows watched the tape, they were able to see many instances in which Joe had been experiencing failure. Furthermore, they saw many places where his Clinician had been punishing him without apparently realizing it. Of course, the Fellows had the advantage of hindsight. They knew that Joe had been experiencing more failure than he ought to, so it was easy to spot the occasions for it. It provided, however, an excellent vehicle for analyzing what happens when the clinician moves through therapy too fast for the client.

In trying to understand why Joe had felt so much failure, the Fellows watching the videotape made a number of suggestions. First, it was not clear that Joe had a firm understanding of how to move through the articulatory sequence of the word. He seemed, still, to be unsure of how to do this particular task. They thought a restatement to Joe of the goals and procedures for this aspect of therapy would have helped. A second suggestion centered around language. The Clinician seemed to be using language that was too sophisticated for the client. It had been observed earlier that Joe was not a highly verbal person and that his language skills were certainly not at the same level as his Clinician's. A more concrete approach and simpler linguistic forms were suggested.

To some of the Fellows it seemed that there were too many tasks during the therapy session that were unrelated to the main goal. One of the tasks involved sentence completion and another one word association. These may have been too intellectual for Joe to handle. It was also noted that on several occasions when it wasn't really necessary Joe's Clinician made it evident to Joe that he had failed a task. For example if Joe was asked to describe an aspect of a picture and he got off the track, his Clinician would say "That's a good observation, but how about . . ." This procedure, although designed to be supportive, left no doubt in Joe's mind that he had been unsuccessful in supplying the right answer and could only have increased his feelings of failure.

In one of the morning sessions that was not videotaped, Joe's Clinician simply reviewed the therapy that had taken place so far. All the team members and Joe were present during this session. The team members were told to simplify their language, to ease off on the assignments, and to make their instructions more concrete. The major focus of therapy from this point on was to assist Joe in learning to use prolongations of continuant and vowel sounds.

Later one of the team members reported that Joe had seen him informally and that he seemed much more relaxed and his speech more forward-moving than it had been all day. Furthermore, he was making a sincere and effective effort to keep his speech going via prolongation.

In the other nonvideotaped session that morning Joe was simply instructed that when he stuttered, he was to stop, write the word down, then "put it back together again." He was also told to say the reconstructed word strongly and as positively as possible, but he was forbidden from using this procedure anywhere but in the clinic. This was carried out for a few moments, but Joe seemed sullen and reserved. The Clinician consequently suggested that they take ten minutes and simply prolong as many words as possible during the discussion. Joe seemed almost instantly more relaxed and cheerful and seemed to be responding with greater ease.

That afternoon an event took place which probably did as much as anything to bolster Joe's morale. It also illustrates good counseling at its best. One of the female members of Joe's team was asked to take him for a coffee break with no more specific charge than to be supportive. When they met, the team member, despite the fact that she was Joe's senior by more than a few years, jocularly referred to their meeting as if it were a date. This joke set the tone for the interaction which followed. Throughout the afternoon Joe played a protective role, opening doors for the team member, paying for her coke, and so on. Because he was playing this role, the team member was able to verbalize some feelings she had had that she would be unable to live up to the expectations of those who had chosen her for the Institute. This gave Joe, from his protective role, the opportunity to counsel her with the same kind of advice that he needed. This did indeed take place, and in the counseling he was himself apparently counseled. A number of similar interactions took place with regard to other topics, and Joe apparently left the situation feeling not only that he could succeed by doing his best, but probably also that he had helped someone else over similar difficulties.

The next morning, in the review session, the team members who had seen Joe the preceding afternoon and evening all confirmed that he seemed to have a more constructive attitude. He had made a contribution in the group therapy session, and he had made several statements along the lines of "I think I can do it." One of the team members reported that Joe had described life in the trailer with the other two clients and that although he liked Allen he found Bob hard to take. It was hard for Bob, who had become quite fluent, to keep from talking and he had apparently said some things, in comparing

his performance with Joe's, that would have been better left unsaid. The antagonism between them soon passed, however.

Since Joe's videotaping was scheduled for the middle of the three therapy sessions, his first session in the morning was not videotaped. Joe's Clinician introduced the session by telling him from the beginning that if he did not understand the language that was being used, he was to interrupt and ask for an explanation. In a therapy session which took place later in the week Joe did this several times. The goal for this first session was for Joe to identify occasions on which he stuttered with force or struggle or occasions when he avoided or delayed a word. Once these events were identified, Joe was to stop and then go through the following routine: (1) integrate the sound, (2) integrate the syllable, and (3) say the word slowly with strong deliberate movements. Joe was also instructed that he would be rewarded for smooth easy stuttering. The session began with concrete, automatic language, such as counting and reciting the days of the week and progressed through single word utterances to short semiautomatic phrases such as "get off my back." Joe seemed to be responding positively to these assignments, and the team moved into the videotaped session.

The purpose of the videotaped session was to increase Joe's ability to maintain ongoing speech by the techniques outlined in the preceding session and to do so with increasingly complex utterances. A secondary purpose of the session was to provide a more easy-going or humorous evironment in which Joe would be more relaxed. They were trying to loosen him up. Joe was given demonstration and practice with easy prolongations through progressively more difficult situations. He was extremely successful in doing this, and the tension was lower than ever before. There was more laughter and kidding around and much less confusion than in previous therapy sessions.

There was no more therapy that morning for Joe, and that afternoon, instead of a formal therapy session, a pretty freshman from the University who had expressed a desire to major in speech pathology came to see Joe's Clinician for advisement while Joe was there. Both of them stuttered in front of her, but she showed no reaction. At one point, however, she fragmented a word, and Joe smiled and seemed to enjoy it. An effort was made to make sure that Bob saw Joe and the young girl leave the clinic together. This was done to offset the feelings of inadequacy that Joe apparently felt when he compared himself to Bob.

By Friday, Joe seemed to have thoroughly grasped the technique of prolonging continuants and vowels and of moving through the word rather than freezing up on the initial consonant. There was also an indication that he was not just following in ther-

apy but taking some of the responsibility himself. At least, he resisted on one occasion letting the Clinician put words into his mouth. During the videotaped session he recounted his experience of the preceding evening in which he had tried to make a phone call to his girl friend at home. Although he was unsuccessful in reaching her, he handled his speech well while talking to the operators and was pleased with himself.

In an informal afternoon session, he commented that his girl friend used to do a lot of talking for him, but that now he was going to do the talking after he got home. In the group therapy session that afternoon he made several contributions. Ego support continued to increase as his Clinician described him as a "beautiful person" in the group therapy session, and two of the female team members went out with him that evening, and discovered that he was a very good dancer, and told him so.

During the discussion session following the videotape, the Fellows tried to analyze what it was that had been most significant in bringing about the change in Joe's attitude. The informal counseling sessions and the amount of approval and support he received must have had a major effect. But the primary cause was felt to be the change in therapeutic strategy, principally the change from a punitive to a nonpunitive therapy, and from a complicated and verbal set of tasks to a more concrete and simpler approach to rehabilitation. There was also a change in goals – a reduction to more realistic ones.

Most of the week was spent in attempts to alter Joe's attitude. Some actual therapy was done, and this was probably successful. But the change in attitude was necessary before therapy could be undertaken. Joe might have packed his bags and gone home if his mood of depression and failure had continued. Even if he had not gone home the continuation of therapy with such an attitude of defeat would have had little value.

Allen Williams

During the first few days of the Institute and over the weekend before the actual therapy began, Allen's Clinician gave him a number of assignments in reading as part of the educational phase of his therapy. He was given a number of books to read on the speech process and on stuttering. He was also given a glossary of terms that the Clinician or team members might want to use to describe aspects of speech or stuttering. Allen seemed to carry out these assignments with enthusiasm and gained a superficial understanding of the speech mechanism.

On Monday the Clinician's plan was to discuss Allen's stuttering with three purposes in mind: (1) to have him describe his specific stuttering behavior, (2) to have him relate that behavior to his own personal model of his stuttering, and (3) to have him produce a therapy plan in terms of his specific behavior and his model. It was not anticipated that these goals would be achieved on the first day; they were long term goals. In the first session that morning, one of the team members reviewed the lesson plan with Allen and checked on the assignments he had been given on Friday. They discussed the speech process and mechanism, and it was apparent that Allen had not only acquired a rudimentary knowledge of speech but was beginning to relate his own speech behavior to this information. He seemed less sophisticated, however, in talking about his stuttering and its causes.

In the second session of the same morning the discussion continued with Allen's Clinician and the entire team present. This was essentially a therapy planning session, and, since Allen was going to learn how to be his own Clinician, he was of course included in the planning. Most of the session, however, was a continuation of the discussion that had begun in the first session. The Clinician felt that Allen still needed more information, and he conducted a teaching session concerned with fluency breakdown. The role of difficulty in language formulation, articulatory sequencing, and negative emotions such as fear, and their influence on the flow of the articulation process were also related to Allen's stuttering. It was decided to continue the discussion about dysfluency and the reason for it, with particular emphasis on the effect of emotional states, into the videotaped session.

During the taped session Allen seemed to have a difficult time formulating answers. He would frequently be silent for a few seconds and then say that he "couldn't think straight right now," that his mind had "gone blank." The Clinician suggested that Allen may have been having difficulty formulating his ideas because of fear, and Allen agreed. On several other occasions Allen mentioned tensions in the vocal cords, and the Clinician asked him to tense them voluntarily several times. This seemed to heighten his understanding of the process.

During the viewing of the videotape the group commented primarily on Allen's long silences. They were not certain whether the silences were really caused by difficulties in language formulation, as Allen said, or whether they were simply avoidance devices to keep from stuttering, or perhaps some combination of the two. Perhaps Allen began by having real difficulty formulating language because of

fear, progressed to an avoidance behavior, which, when it became habitual, differed only trivially from "real" difficulty in language formulation.

In the sessions that followed the videotaping, Allen was given an assignment to collect introspective data about fears and anxiety, and to analyze the relationship of these emotions to his stuttering behavior. Allen's Clinician asked him how he felt about his therapy at this point, and Allen said with extraordinary self-reliance that he thought he'd be able to speak much better when he left at the end of the summer, not because he had faith in the Clinicians, but because he had faith in himself. He thought the information he was receiving would help him to know how to handle his stuttering, and he felt that the time that he would have to think about his stuttering in great detail would help in solving his problems.

In the afternoon session, Allen continued to explore, with one of the team members, the identification of his dysfluencies. There was a tendency for him to discuss the question in an academic manner rather than with concrete reference to himself, and he was discouraged from it. Together, Allen and the team member worked out a plan for recording specific aspects of his stuttering. They broke the speech process up into several categories: breathing, tension, thoughts, situations, body movements, the articulators, vocal folds, and facial expressions. Some of these categories were held in abeyance for the time being – specifically tension and situations – but the other categories were compared for fluency and nonfluency. Allen noted that when he was nonfluent his breathing was characterized by a holding back of air. When he was nonfluent his thoughts wandered and did not stay within the context of the conversation. When he was fluent his hands were motionless, but when he was nonfluent he played with things and his hands wandered "all over the place." When he was fluent his articulators behaved normally, but when he was nonfluent they "don't move in the right place at the right time. I have no way to control the block by moving them except by stopping what I am saying." As far as his vocal folds were concerned, Allen noted that when he was fluent they behaved normally, but when he was nonfluent they "vibrate too much. There is not enough muscle control, or practice using them." Allen also noted a number of facial expressions. After this outline had been worked out, Allen asked for some additional time to think further about it.

In the second afternoon session the entire team was present. The Clinician first reviewed the therapy procedures up to this time and then described what might be happening during some of Allen's nonfluencies. There was a detailed discussion of noxious stimulation

after the Clinician steered Allen away from an interest in physiological variables that were probably irrelevant, such as the oxygen supply to the cortex. At the end of the session Allen was given assignments for the following day: (1) to verbalize the concept of laryngeal blocks in terms of his own perception, (2) to identify some of the noxious stimuli that give him trouble, (3) to continue his analysis of what happens during nonfluencies, and (4) to analyze his own speech and that of his roommates.

On the second day Allen's Clinician wanted him to discover and talk about some of the specific stimuli associated with his blocking, since he had so far identified only very general stimuli such as "I block when I am tense or talking to strangers." The second goal for the day was for Allen to produce verbal accounts of his speaking behavior and stuttering. A third goal was for Allen to begin to produce some therapy plans for the block and to share them with the team. To achieve these goals Allen's Clinician asked him to review what he had done so far about his stuttering and to explain what his current concept of his stuttering was. That day, Allen would also watch his videotape from the day before, give a short speech about some topic of interest, and describe the other stutterers' behavior, contrasting it with his own. Following that, Allen would present several, at least three, reasons for the type of block he experiences, with possible therapies for each reason. Finally, he was to talk about a selection from among these therapies.

In the first session Allen watched his videotape of the day before and talked about his stuttering. He reported "I don't plan a sentence before I say it and I start some of my sentences with an 'uh.' " The Clinician asked Allen to analyze his use of the interjection "uh" in a more descriptive manner, but Allen was unable to do this. During the session Allen indicated that one of his better speaking situations was in front of groups, or at least it was a situation in which he felt he could be a good speaker. The Clinician suggested that Allen might want to prepare the outline for a public address, but Allen resisted the suggestion.

During the second therapy session of the morning all of the team members were present. One of the primary purposes was to continue having Allen verbalize about his stuttering. How long, the Clinician asked, did Allen think he could speak without having repetitions. To answer it, Allen suggested that he read from a book while being recorded. He did this and then read the same passage again. During the second reading, the Clinician interrupted and occasionally made comments about how Allen might modify his rate to see if rate was a factor in laryngeal tension. The Clinician also made

some attempt to determine what effect different situations might have on the amount of stuttering Allen would experience while reading out loud, and Allen reported that the presence of strangers and a larger audience would make him stutter more. There was some discussion of Allen's reading skill, and he felt that his performance was poorer than average. Two of the team members took it upon themselves to analyze his dysfluencies during the reading. Allen's speech during the session was louder than before, and there was an increase in the number of syllable repetitions. It was noted that he had difficulty articulating a substantial number of words – *civilization, parallel, evolving,* and *articulation.*

In the videotaped session Allen read out loud and spoke extemporaneously on a subject with which he was familiar in order to see (1) if the presence of the camera had an effect on his speech, (2) to see how increased tension affected his speech, and (3) to make a tape that he could use for later analysis. During the taping Allen read from *The Speech Chain* for three minutes. He had some brief repetitions and hesitations. At one point he appeared to have lost his place, and there was some question whether he really had or whether it was an avoidance behavior. He then spoke extemporaneously about judo, having a few severe dysfluencies and losing his train of thought several times. The Clinician then asked him to defend a point of view about karate, and the frequency of dysfluencies increased substantially, oscillation of the jaw became more pronounced, and his vocal quality seemed to be more tense. Finally, the Clinician asked him to analyze what was happening to his speech during these more dysfluent utterances. When the tape was shown, Allen commented on what he had seen only briefly. He wanted more time to think about it.

During the discussion of the videotape later that afternoon the Fellows were uncertain whether Allen's rather frequent lapses into silence in which he said he had lost his train of thought and the two occasions on which he lost his place while reading were genuine or whether they were avoidance behaviors or postponement devices. It was noted that these devices would have to be either sophisticated avoidance devices or evidence that Allen had some form of minimal central nervous system impairment. One of the Fellows said that Joe had reported in another therapy session that Allen talked differently back in the trailer, that he did not have so many silences, and it was noted that this variation from one situation to the next was not consistent with the CNS impairment hypothesis.

Allen spent the afternoon therapy sessions analyzing what happens during his repetitive blocks. The repetitions, he felt, were related to the surroundings in which he found himself. He acknowledged

the part played by tension, but thought difficulty in formulating language was a more important factor. After some discussion with the Clinician he came to realize that normal speakers, as well as stutterers, were frequently unaware of what they were about to say. As the discussion centered more and more around anxiety, Allen clarified something we had suspected, that his anxiety over his speech often caused him to withdraw from communicative situations and not talk at all.

In the second therapy session of that afternoon the goal was to pull together Allen's understanding of the processes of communication and to relate them to his stuttering. The Clinician brought up three areas: feeling, fluency, and language. As far as feelings were concerned, Allen reported a generally high expectation of fluency and a very strong negative reaction to nonfluency. The Clinician analyzed Allen's speech as follows: The syllable repetitions and oscillatory behaviors are noxious stimuli that lead to revisions and word and phrase repetitions. The lack of language formulation also produced tension, which, along with other tensions, made it even more difficult to formulate language. He then asked Allen if this analysis were accurate but did not receive a response. The notion of difficulty in phonological sequencing was also raised, but Allen did not respond to it. With regard to another problem, there seemed to be no question that Allen's inability to attend was more prevalent when he was anxious, but it was not clarified in this session whether the inattentiveness was a bona fide avoidance behavior.

One of the team members recorded observations on Allen's speech during the session. He noted several grammatical errors that seemed inappropriate for a college sophomore along with several types of dysfluencies. There seemed to be two kinds of syllable repetitions, one very short and another, longer one which often resulted in stoppage and repetition of the word. Both types occurred more on vowels than on consonants. Vocalized pauses such as "uh" were also interjected within words and phrases. The team member saw some facial muscle tremors and some gestures he considered inappropriate, possibly timing devices.

In the first session on Wednesday Allen was asked to talk about what he felt were the essential aspects of his communication problem and the interrelationships between them. The idea was to get Allen and his Clinician to agree on what needed to be changed. Allen felt that the most important aspect of his blockage was excessive muscle tension. The Clinician explained that there were forms of therapy for achieving relaxation but mentioned also the need to eliminate visible abnormal behaviors and the attitude or desire to be perfectly fluent which can lead to more avoidance behaviors. There was a continuing

discussion of various types of noxious stimuli, including the tension of the dysfluency itself. This prompted Allen to say that he was interested in learning pull-outs, which he had read about in one of his books, but the Clinician noted that this was a technique to be used during the block, and at the moment the major focus of concern was on what Allen was doing before the block. The Clinician asked the team for suggestions for symptomatic therapy. Discussion followed and at the end Allen decided that he would like to learn how to do preparatory sets.

In planning for the videotaped session, Allen's blocks were related to his feelings about them. Allen wanted to get rid of his anticipation of the block, but the Clinician suggested that if he could handle the blocks the anxiety of anticipating them would decrease. During the planning session it became evident that Allen was already using preparatory sets.

At the beginning of the videotaped session, Allen's Clinician recapitulated the client-clinician relationship that had developed up to this point and expressed his satisfaction with the way in which Allen was playing his part. Allen said that he was also satisfied with the way this relationship was evolving but felt some impatience that therapy was not more intensive and made some specific suggestions for intensifying it. The discussion turned to Allen's difficulty in language formulation, and he made the following statement: "I have had no experience in talking. It is mostly my fault because I never wanted to. But lately I have decided that I want to." He expressed a strong need to acquire the central verbal skills that he felt had been so neglected in his experience. He then went on to suggest a number of activities that would improve his therapy, and although the Clinician agreed that most of the activities would be beneficial, he emphasized that it was up to Allen to initiate them. At the end of the session the team evaluated the preparatory set revisions that Allen had been using.

During the afternoon therapy session, Allen said that he had thought about his therapy and had set up some goals for himself. He wanted to try and use preparatory sets during "talks" given during the therapy sessions, and he wanted someone to count the frequency with which he used these preparatory sets successfully. The Clinician agreed to this, and three such talks were given. The first talk was a simple narrative description, the second was a step by step account of how to change a flat tire; and the third was an argumentative monologue on politics. The successful preparatory sets were counted, as were the number of dysfluencies. When the argument became heated, there were more dysfluencies, but the percentage of successful preparatory sets rose to 75 per cent by the end of the session.

After watching the videotape later that afternoon, the Fellows made several interesting observations. First of all when the Clinician asked for some feedback from Allen about how therapy was going, Allen asked for more *variety* of experience. He also asked for instant correction, immediate feedback, from the team members as to whether he had performed a preparatory set successfully or unsuccessfully. The Fellows felt that he was beginning to put his finger on the kind of conditioning that he required.

On Thursday Allen's Clinician had two goals for the day: (1) to increase the social stress and the language complexity of the situations in which Allen was to do therapy, or at least in which he was to talk, and (2) for Allen to increase his therapy planning behavior, setting specific daily goals for himself and evaluating his achievement of them at the end of the day. He also wanted Allen to act as chairman for the planning session that morning and if possible to interview some outside figure, such as a Consultant.

Before any therapy took place, one of the team members recounted at the morning review session that Allen had come to his cabin the night before and requested some therapy. Allen was highly assertive and assigned the team member a role as listener while he read aloud and spoke spontaneously. The team member was then told to defend the capitalistic system while Allen argued against it. According to the team member Allen had fewer repetitions than on previous occasions, but his hand movements had increased or at least not decreased as much as the repetitions. Two other team members reported Allen being equally assertive with them although he had not asked for therapy.

In the discussion at the review session it was suggested that Allen had a more severe communication problem than the other two clients, although he was not as severely dysfluent. When he requested his team member to defend capitalism it seemed like a bizarre and peculiarly specific request. Later, however, it became evident that his friends were accustomed to discussing political questions and it was essential for Allen's identification with his peer group that he be able to participate in these discussions. In this light his request was not bizarre at all. It was noteworthy, however, that he failed to communicate the normality of the request. A less severely impaired person would have made an attempt to make his request seem reasonable. Several similar events occurred, in which Allen said something that seemed at first very peculiar but later turned out to be quite reasonable. Each time the misjudgment was caused by poor communication.

In the first therapy session that morning, Allen was told to chair his planning session and to assume more responsibility for his ther-

apy. The Clinician's goal for the session was to teach Allen how to set goals, goals the achievement of which could be measured at the end of the day. Allen began by recounting his activities since the last session, which included conversations with the other clients and with some members of the local judo club. He described how many blocks he had had and how successful he had been in using preparatory sets for each of these different speech situations. In the evening he had attended a poetry reading by Eugene McCarthy and afterwards talked with a girl he had met there. He reported having had only one block "which is unusual for me." (He would ordinarily not have had any while talking to a young girl.) When Allen had finished, the Clinician analyzed his speech behavior of the past few moments. He said that Allen had to become more accurate in identifying his blocks and suggested that if he spoke louder it might help. Allen was asked about how fluent or dysfluent Senator McCarthy had been, and he thought he had been quite fluent, although most of the team members felt he had been remarkably dysfluent. Later, Allen tried to get a copy of the tape made at the poetry reading but was unsuccessful.

Allen found it difficult to establish specific goals, as his Clinician had requested; he said he didn't know exactly how to go about it and that he would like to have more practice working with specific techniques on the blocks. He also said he needed to practice these techniques in situations with more pressure. He was given an assignment to call and make arrangements to listen to the McCarthy tape. The Clinician asked Allen about other anxiety-producing situations, and he suggested introducing himself to faculty members of the University and talking to them. There was some concern among the team members that it would be better for Allen to get more proficient in handling the blocks before going into highly anxious situations, but Allen felt that his main goal was to talk fluently and he wanted to do so in a tense situation and still "make sense" in what he said. The Clinician reminded Allen not to overlook the visual aspects of his speech pattern. The team noted in this session that Allen had been better able to verbalize his ideas. They wondered though if there hadn't been an increase in his visual behaviors, particularly his lip and jaw tremors and his hand and arm movements, but because there had been no frequency count of these behaviors before therapy it was not possible to confirm the idea.

For the videotaped session the plan was to have Allen speak in a pressure situation of his own choosing. Plans were also made to take closer pictures of Allen's face so that he could review the tape afterwards and analyze this aspect of his speech pattern. Allen suggested that he interview Dr. Murphy, who was the Consultant for the week, because he felt it would be a pressure situation. He made all the

arrangements for the interview, confirmed it with Dr. Murphy, and then reported the arrangements to the team.

On tape, the interview began when Allen asked Dr. Murphy a number of direct, personal questions about his family life. Later in the discussion Allen talked about his own family life. Most of the interview was an exchange of personal attitudes and feelings about people, speech, and particularly about stuttering. At several points during this interview, the conversation broke down and Allen made a concentrated effort to keep it going by redirecting the topic of conversation. He was not entirely successful in mastering the situation, although his speech was considerably better than it had been previously. Only once was there a failure of language formulation, and Allen was more willing to talk about himself than he had previously been.

In the afternoon individual therapy session, Allen first reported on his assignments to make phone calls earlier that morning. He had little difficulty with it and wanted now to turn to some of the methods by which he could reduce his anxieties. He also wanted to spend some time just talking, "so I can perfect my speech." A discussion followed on the nature of anxiety. Allen felt that one of the reasons he was anxious in speech situations was that he had never been able to sit down and talk about it with anyone. The team member pointed out that anyone with a communication problem would be expected to have more speech anxiety than others. When asked to describe the situations that made him feel anxious, whether related to speech or not, Allen listed talking with his father, particularly in an argument, and talking in front of a class or to strangers. The team member then drew an analogy between anxiety before a karate match and anxiety before a speech situation, emphasizing the effect on performance, and from Allen's reaction the point was well taken. At the end of the discussion the team member asked for an evaluation, and Allen indicated that he was satisfied with the therapy session: "I wanted to talk to someone besides a friend about this. It was helpful. I can put it to practical use."

In the second session that afternoon Allen was asked to evaluate his progress in therapy so far. He felt that he had improved somewhat and said "Once I can cope with blocks I won't forget them (referring to the techniques), and it won't come back." He also said "I've gone past the hard part," noting that he was less anxious now. During this session the following exchange took place:

> Allen: Yes, that's where I want to be; fluency. But I want to formulate my language better.
>
> Clinician: At the end of the three weeks do you want controlled blocks or no blocks?

Allen: No blocks.
Clinician: Where are you today?
Allen: I can do it in some situations.

Allen's Clinician suggested that he watch a videotape recording of his speech at this point so that he could analyze its visual and acoustic aspects more closely. The Clinician also asked if Allen had put himself in phone call situations during the day or approached the anxiety he would feel in making a call in his own town. Not answering directly, Allen indicated his anxiety level had lowered to some degree and that he had methods for lowering it further. At this point, he had a block, and the Clinician asked him if he still wanted to work on pull-outs. Allen said he thought he should know how in case the preparatory sets fail. The Clinician said "When do you want to start?" "Tonight I'll read the book on it and begin," Allen replied.

Late that afternoon, an extra therapy session was held in which Allen watched a videotape of his speech, identified his visual behaviors, and related them to his speech pattern. Eye blinks, lip movements, and eyebrow excursions were identified and voluntarily practiced for the purpose of increasing Allen's proprioceptive awareness of them. Allen wondered if the eyebrow and eyeblink behaviors were abnormal, and to answer the question he was told to count these behaviors in two-minute segments of a nonstutterer's speech and then count his own.

The next morning Allen's Clinician said he felt that the discussion on anxiety that had taken place in the first afternoon session was the most crucial moment so far in Allen's therapy. He also reported an extraordinary sequence of events. Allen had visited him the night before at his cabin (It was the first time he had done so.) and asked for the name of a public address instructor at the University. The Clinician didn't have this information available and Allen returned to the trailer. Not wishing to lose the opportunity, however, and in order to put a little extra stress on Allen, his Clinician went over to the trailer at 7:40 the next morning and suggested that Allen get up and go to an 8:00 class in public address. Allen hastily got dressed, and his Clinician drove him to the speech office, where he arrived at 7:55, not knowing where the class was or whether he could sit in on it. He sought out the appropriate instructor and asked him if he could sit in on the class and was granted permission. Apparently he handled the entire situation masterfully.

In the first morning therapy session on Friday, Allen's Clinician requested some more feedback from Allen about his plans. Allen had them well formulated. He planned on counting repetitions three times daily – in one morning session, in one afternoon session, and at night while talking to a team member of his choice. He also

indicated that he was just beginning to learn how to control his blocks and he didn't think therapy should go too fast at this point. His Clinician suggested that he use the upcoming weekend as a stabilizing period, but continue to make phone calls.

When Allen was asked to describe what happened that morning after he had been dropped at the speech department office, he said that the professor had asked him to give a speech the following Thursday on the frustrations of stuttering. With characteristic self-confidence he said he thought he could give it sooner than that. The Clinician counseled Allen to slow down a little and make sure the speech was a good one so that he would have a successful experience. Shifting the conversation, the Clinician gave Allen a small lecture on the autonomic nervous system, including an outline of systematic desensitization. Allen then reported that the previous night he had given a twenty minute talk, unrehearsed, to a local karate group. He felt that he had handled it well, commenting that two weeks ago it would have taken him three hours to say the same thing. During the talk, he had controlled most of his blocks but slipped a few times. Unexpected as this information was, Allen's Clinician did not comment on it. Instead, he asked Allen to describe what he had seen when he watched the videotape. In reply, Allen said that his odd facial expressions had bothered him the most; he voiced his determination to overcome them. He thought his lip tremors were voluntary and said he thought he could stop them if he tried hard enough, but his awareness was not high enough for him to feel the tremors beginning, at least not all the time.

While planning for the videotaped session, Allen's Clinician asked him how much he knew about anxiety. Allen told him that it varied from situation to situation, and a discussion of anxiety ensued, during which Allen monitored in the mirror the visual aspects of his speech. This activity continued into the videotaped session which followed. The Clinician asked Allen to relate previous experiences in which he had been highly anxious so as to precipitate some actual blocks. Allen recounted some of his childhood experiences in school, but no blocks occurred. Sensing that Allen's awareness of his speech behavior was too low, the Clinician decided it would help if Allen could learn to fake stuttering. But Allen had to make the decision. In order to lead him to it, the Clinician asked Allen if the stuttering of the other two clients was a noxious stimulus to him, and he said it wasn't because their stuttering was so different from his. The Clinician then demonstrated his stuttering for Allen and they compared their respective patterns. Allen was then asked if he could tell the difference between a faked block and a real one. He said that sometimes the faked ones turn into real ones and the real

ones can also turn into faked ones. When asked if he could fake some blocks, he said "I'm not good at stuttering when I want to, but I'm real good at it when I don't want to." The Clinician asked Allen if he thought faked blocking would be useful for him as a therapy technique, and Allen said it would help if he could get into the blocks voluntarily.

During an afternoon therapy session a tally was made of Allen's short repetitions, his long repetitions, and some of his facial movements. The upcoming public speech was discussed briefly, and Allen expressed confidence in being able to prepare for it over the weekend. The session concluded with Allen making a phone call. While waiting for a line, Allen began an extended story about an incident that occurred on a karate team trip. The time elapsed during the story-telling was two minutes and twenty seconds. During this time eight preparatory sets and five short repetitions were counted. Allen reflected with satisfaction that he had never before told an anecdote of that length. He seemed to enjoy the experience greatly. As he started to make the phone call, he was verbalizing his actions in looking up the number. He then became self-conscious and concerned that this was unusual behavior. The team member who was with him reassured him that it was perfectly normal, but it was cited as another indication of Allen's verbal inexperience and naivete.

The second afternoon session was held in the snack bar at the Student Center because Allen said he was beginning to get used to the team and the familiar surroundings of the clinic. Following Allen's earlier instructions, the Clinician and the whole team talked loudly in order to draw the attention of those sitting near them and then proceeded to haze Allen, interrupting him, changing the subject, asking him to repeat or talk louder, and blowing cigarette smoke in his face. All this apparent stress and frustration, however, failed to produce an excessive number of fluency failures, and the Clinician complimented Allen on his success. Allen then reported on his preparation for the speech he was to give the following week, and it was determined that the team would be available to him for tutoring.

At the end of the first week Allen had gained some understanding of speech and of stuttering and was even beginning to understand *his* stuttering. But because Allen was being given free rein in how to look for this understanding the story of his finding it is necessarily disjointed. He didn't have the advantage, as the other clients did, of having goals and procedures determined by his Clinician; he had to determine his own, and in doing so went up a number of blind alleys. It was hoped, however, that the skills he would acquire in the process would serve him well, long after the summer was over.

Robert Roth

During the first few days of the Institute, before any formal therapy was done, Bob experienced one of the benefits, and also one of the pitfalls, of residential intensive team therapy for stutterers. He came from the daily pressures of the city, from an environment characterized by constant and often hostile evaluation of his performance. From this environment, he came into a small community of about 30 people in which his stuttering was completely accepted, perhaps even encouraged, if only for the sake of analysis, but more importantly an atmosphere in which he was totally accepted as a person. In this atmosphere, Bob became fluent almost immediately. Some therapy was done during these first few days in which Bob was asked to identify, locate, and describe his stuttering behavior. It may be that the sudden change in fluency resulted from this early therapy or from a placebo effect associated with it. It seems more likely that his fluency resulted from an absence of the old feared situations and an absence of the need to be fluent. Whatever the cause, Bob was almost totally fluent by the time formal therapy sessions began on Monday. This created a substantial number of problems for the Clinician, whose therapy plan for analyzing and describing stuttering behavior was nearly useless in the face of so few behaviors to work with.

In the first session on Monday Bob was asked to analyze his expectancy of stuttering – when it occurred, what word it occurred on, and his manner of recoiling from it. He was also asked to identify the particular word that gave him difficulty. There was so little stuttering, however, that there were few opportunities for this analysis to take place. The Clinician rushed him in order to precipitate some blocks, but it had very little effect. From the small sample that was seen, however, it appeared that blocks were not expected until immediately before the trouble word and that many of the blocks were unexpected. The expected blocks were all but imperceptible, often identifiable only by the client, and the unexpected blocks were light, but noticeable repetitions.

In the videotaped session, the Clinician planned on teaching Bob a number of different strategies for modifying stuttering, but there was so much success with the first one that he decided to continue with it through much of the session. This technique was described to Bob as "moving forward through the word" rather than backing up and restarting. After a few demonstrations, Bob grasped the idea and applied it to his own speech. Several times, the Clinician tried a second therapeutic technique, having Bob stop during a block and prolong it so as to get the full experience of blocking and so as

to learn how to resist the drive to escape. There wasn't, of course, very much opportunity for Bob to experience blocking, because there was so much fluency.

After watching the tape later in the afternoon the Fellows were concerned about the sudden fluency. Was it false fluency? What was false fluency? If it was true that Bob was fluent only because his new surroundings were generally positive and different from his old ones, then the fluency was "false" in the sense that it would not be sustained at the end of the summer. It could also have been "false" because it was due only to the effect of suggestion. This hypothesis was just as tenable as the other one in light of how readily Bob had been observed to respond to suggestion. (In his evaluation, he had become fluent under DAF, electrolaryngeal speech, and after one reading of a passage.) Presumably effects due to suggestion alone would also fail to be permanent. There was one genuinely positive effect of this therapy session – Bob learned several ways to modify his stuttering. The Fellows noted that his Clinician used good shaping procedure in reinforcing him in the beginning for any approximation of the task.

In the other nonvideotaped session that morning, a further attempt was made to decrease Bob's drive for fluency. He was shown pictures of people failing to achieve certain goals, unrelated to speech, as a result of trying too hard or struggling. Despite what would seem to be an obvious analogy, this device was not successful in changing Bob's attitude about fluency as evidenced by his statement "If every word I blocked on, I could push my way through, I could speak." It was noted during this session that Bob continued to describe his stuttering pattern in the third person ("the jaw goes up and down," and so on). The method of voluntarily modifying his blocks and changing them from struggling to easy stuttering to fluency was demonstrated to Bob, and he learned it without difficulty.

In the first session that afternoon Bob's Clinician had him imitate his own facial movements and describe his distraction and timing devices. Bob was quite good at imitating himself and accomplished the tasks without difficulty. At one point during this session he made several attempts to see the people watching through the one-way mirror. He seemed concerned that he could be seen without being able to see the observers.

In the second session of that afternoon, the plan was to pinpoint the situations or events that caused Bob to feel communicative stress. In order to do this, one of the team members took him downtown, and together they worked out a number of ways Bob could approach strangers and talk with them. They found that one stressful

situation was when a listener said "what?" and wanted Bob to repeat something. Another was the impending need to speak. For example, if Bob saw someone walking toward him who was about to address him he would feel fear. Policemen were also identified as sources of stress. During all of this activity, Bob was highly cooperative and initiated some really stressful encounters for the precise purpose of discovering how stressful they would be.

In discussions at this time the Fellows continued to comment on Bob's willingness to please those around him, a trait which they concluded was related to an intense need for approval. They also speculated on the extent to which this need for approval might take the form of a high drive for fluency. From such a drive, struggling for fluency, and then stuttering, could result. In this light, Bob's early fluency may have come about because the accepting and secure atmosphere of the compound defused this drive. The Fellows had to remind themselves not to reveal their delight at Bob's fluency since this, along with Bob's need for approval, could have reinstated the drive for fluency. Early as it was in the four week schedule, the Fellows began to wonder how Bob would do if he were to talk to his friends in Brooklyn or to members of his family. Since the Clinician had similar concerns, several telephone calls were planned as assignments.

On Tuesday, symptomatic therapy was continued, but Bob was also given an opportunity to discuss his feelings about stuttering. In the first session he had the double task of discussing sources of frustration he had experienced and at the same time, if he should have a block, to say the word again with loose contacts. He seemed partially successful in using the loose contacts and listed several frustrating situations. During the session, Bob was generally fluent, and the Clinician asked how he might increase pressure. Bob suggested an increase in audience size, and the secretary was asked to come in and listen, but there was no increase in stuttering.

In the second session that morning Bob observed some of his team members under delayed auditory feedback for the purpose of heightening his awareness of the dysfluencies of others and as an emotional release for himself. He seemed to react ambivalently to the sight of his therapy team apparently stuttering involuntarily. There was evident pleasure, but also some concern when one of the team members ran into real difficulty. Bob was then put on the DAF in order to heighten his awareness of proprioceptive feedback, and although this may have occurred he was not able to ignore his auditory signal. He was then asked a number of questions by his team. His job was to (1) plan silently, (2) rehearse with whisper, and (3) answer the question. Since he had indicated before that his assignments did not

seem very real when his team members or listeners were aware of them, this assignment was kept secret from the team members while it was being carried out. Some of them seemed to understand at least generally, however, what the assignment was. Bob continued to be fluent during the session except on one occasion when one of the more authoritarian team members challenged his statement.

The videotaped session that morning was similar to the preceding session in that Bob was taped, first discussing the effect of DAF on his team members and then discussing what it felt like for him to be under DAF. He was instructed to keep "moving forward" and to resist the use of any body movements to attain fluency as he engaged in the description. This seemed to be a successful technique. Changing the instructions, Bob's Clinician asked him to scan ahead for trouble words and silently rehearse them until he had a feeling for the movement as he continued in his description of the morning's activities. This assignment was also carried out with great success. Again the instructions were changed, and he was asked to identify and imitate postures and behaviors he used during blocking as he continued in his description. This was also done well.

In this session, Bob reported that during a difficult block his vision "fades." This feeling of fading vision, which later came to be called his "conk-out," was a topic for much discussion later on during the summer.

After watching the tape, the Fellows felt that Bob should be subjected to more pressure since he seemed capable of standing it. They noted that he was still using a description of his stuttering in the third person.

That afternoon, in therapy with one of his team members, Bob was asked to answer a series of questions. While doing so his assignment was to whisper the first sentence of the answer, then to utter the sentence. If he failed to move forward at any time during the answer he was required to wait one minute. This procedure was carried out for a while with apparent success. Bob was then sent out with a team member to make several phone calls, taking note of his feelings while doing so. He came back and reported that he had had difficulty getting someone at home and that when he had finally made contact he rushed through his sentence. He was asked to repeat the assignment and again reported that he had tried to escape from the situation. As he reported this "failure" his stuttering seemed to increase.

In the second session of that afternoon Bob was asked to locate words in which he distorted the vowel sound, a salient characteristic of this stuttering pattern. Unfortunately, very few vowel distortions

occurred, although he showed more stuttering than he had earlier that day, probably because the team member with whom he was having the session was one he saw as an authority figure. The question was raised, however, that if the stuttering was increasing in frequency, it was not clear why the vowel distortions were decreasing, unless perhaps this behavior had been unintentionally modified along with other behaviors that had been worked on earlier.

The first session Wednesday morning was probably one of the more important sessions Bob experienced, and seemed to be a turning point in his progress during the week. Everyone was aware of how cooperative he was, and how eager he was to please those with whom he was interacting. This need for approval made him likely to answer a question the way he thought the questioner wanted it answered, which meant that he was not taking even minimal responsibility for his own therapy. As a result, it was determined to have a therapy session in which the goal was to help Bob make his own decisions and not simply say what he thought was expected of him. To set the tone for the session, the team member told Bob that he could choose the topics for discussion. He talked briefly about several superficial topics, and then decided to talk about "what the people expect of me at home." He felt that they would expect him to be fluent and he said that he wanted to be fluent *for them*, but he realized that he should be fluent for himself. Later in the session he reiterated this statement. He also expressed some surprise at the strength of his drive to be fluent. There was the beginning of an ambivalence between his strong drive to be fluent for himself and for others on the one hand and a slowly dawning awareness that it was his drive to be fluent that was causing much of his struggling behavior. His speech was fluent during this session, so he was told to stand and pretend that he was talking to a class of people on the other side of the one-way mirror. He did this and was disappointed when he found out that there were actually no listeners behind the mirror.

The tack of the session then changed, and he was asked to look for starter sounds. He found none but he noticed an eye movement associated with a tense interjection and tried to imitate it on his own. He said that he couldn't imitate it, it was too habitual, he "couldn't control it." The team member suggested, without being specific, that he use one of the techniques to modify this behavior that he had used to modify earlier behaviors. At first he said he couldn't do that with this eye movement because he couldn't feel it, but he practiced feeling it at the team member's suggestion and became fairly accurate at identifying a slight flickering movement of the eyeball. From this session on, Bob seemed more likely to *apply* what his Clinician had been teaching him, often without prompting.

In planning the videotaped session that morning, Bob's Clinician noted that although he was enjoying his new found fluency he was still missing some stuttering. There were small short repetitions that Bob was overlooking. So the Clinician determined that therapy for Bob would change direction.

During the taping session, the Clinician spent the entire 30 minutes closely analyzing one block. He worked through with Bob the distinction between what made a block real and what made it faked, and he tried to get Bob to attend to proprioceptive stimuli rather than acoustic stimuli in the monitoring of his speech. As part of the analysis, Bob tried to determine with the Clinician's guidance the sequence of events that took place during this particular block. The Clinician probed, asking him how his jaw moved, when it moved in relation to phonation, and where the tension was located. During this session, the Clinician provided Bob with absolutely no feedback about the correctness of his decisions that could be ascertained from the tape. It was a genuinely insightful approach that was being used, with no stimulation contingent upon Bob's behavior. One of the things Bob seemed to discover in trying to analyze the difference between real and faked blocks was that by imagining a listener he could make the block feel real. This suggested that for Bob the difference between real and faked blocking was the presence or absence of anxiety, and this notion was confirmed when Bob declared later that the first cue he felt that a hard block was coming was a sensation of anxiety.

After watching the playback of this tape, the Fellows noted that Bob seemed to have accepted more of the responsibility for his therapy. In contrast, however, some of them also felt that Bob occasionally got too intellectual in analyzing his blocks, but that he would then return to a more direct analysis. There was an oscillation between generalized and specific analysis.

In the last session of that morning Bob was asked to report what he had learned about his stuttering, but his descriptions were vague and unsatisfying. The Clinician encouraged more observations and striving for a greater awareness of his pattern. Bob did seem to begin to understand the relationship of fear or anxiety to certain postures which he adopted during a block. Some of his breathing patterns were also explored in this session.

In the first afternoon session the goal was to locate some of the timing devices Bob used. Taking one of Bob's blocks as an example, the team member asked him to figure out the sequence of events. Specifically, Bob was to try and locate the timer he used to break the run of the block. He found that he used finger and shoulder move-

ments and an eye blink for this purpose. He was then asked to try and figure out where in the blocks he used the timers, and he concluded that he used them in reaction to a build-up of tension. Some advances in Bob's awareness of his stuttering pattern were made in this session.

In the second afternoon session Bob spoke for 45 minutes under DAF. The team member noted that he was most fluent on minimal delay. After the DAF was removed, his speech was quite rapid and contained frequent, rapid repetitions but no hard blocks, and this effect lasted for 20 minutes.

On Thursday an event occurred which seemed at the time to be an important turning point, or crisis, in Bob's therapy. The event itself was momentary, a fragment, and, since it seemed to be unrelated to the events that preceded, it was totally unpredictable to any of us. Trying to understand its dynamics, the Fellows generated many hypotheses. None of the answers, however, had the ring of certainty about them, and we were left only with a sense of how much private experience a client may have of which the clinician is unaware.

In the first session that morning, one of Bob's team members introduced him to the technique of voluntary stuttering. First, she recalled an incident in which someone had used the technique so that Bob could visualize the circumstances. She then gave him a word and asked him to stutter on it. He tried several times without success, and she asked him to speed up the repetitions until he began to feel panic or until he was stuck. At first he was unsuccessful, but after a series of trials he reached a point at which he blocked. He was then asked to try again and when he located the speed at which he blocked, he was to stop and not finish the word. He found it hard not to finish the word, but he did locate the speed at which blocking occurred.

In the second session the same morning the goal was to have Bob locate some of his timing devices and to have him identify repetitions on which he used the wrong vowel. The mirror was removed from the room in order to heighten his attention to proprioceptive cues. Again, the technique was for Bob to analyze the sequence of events in a block, paying particular attention to timing devices and repetitions with the wrong (schwa) vowel.

This therapy continued into the taped session. Bob and his Clinician began the taping by trying to locate certain types of behaviors in a word that Bob had just stuttered on in the preceding session. In order to heighten Bob's proprioceptive awareness, the Clinician began to feel the muscle tension in Bob's jaw and have Bob feel his own jaw under both tensed and relaxed repetition. They were physically quite close. As they continued alternatingly feeling each other's faces, Bob began to look somewhat tense around the mouth

and eyes. When he was asked how it felt when he tensed the jaw, he said "you better not do this," referring (probably) to the use of a tense jaw. He clarified this statement by saying that when the jaw was tense people would know that he stuttered. They spent considerably more time analyzing another word, and at the end both Bob and the Clinician were tired.

In the session following the videotape the incident occurred which dominated the discussion for the rest of Thursday and most of Friday. During this session Bob's Clinician was working alone with him without observers in the next room, so the information is based on interviews rather than on observation. Apparently Bob's Clinician reached out and touched Bob's jaw twice. Bob reacted in some way, indicating that twice was too often. At this time or immediately after, he "broke down." Apparently he cried, but very briefly. No one was very certain about what had happened, and more information was needed before steps could be taken to solve whatever problem there was. Consequently, a team member was assigned to spend the afternoon session with Bob and simply allow him to talk and ventilate his feelings. From this discussion it appeared that Bob felt he was under a considerable amount of pressure, some of it difficult to alleviate. For example, he said he felt that if he changed too quickly his improvement would be sloppy, but if he did not change quickly enough there would not be enough time to get rid of his stuttering. He also said that he felt this was the greatest time of his life, to have eighteen therapists, six "on me alone." In other words, if he didn't become fluent under these conditions, he never would. Much of the discussion centered around his drive for fluency. He mentioned how much better he could do in school and in communicative roles if he spoke fluently. He was also confused and still ambivalent about his motivations. He realized that he should be working for himself, but he wanted to improve for others at home and for others here, "because I know how people are working here and I don't want to let them down." He also noted how different it was for him to be in a situation where everybody accepted him, inviting him into their cabins, as opposed to his peers at home who were not so friendly. But at the same time he was concerned that the Fellows were not accepting him for himself, that they were interested in him only because they were his Clinicians. At one point he asked the team member directly if she were there to learn about stuttering or to help him.

In summary, Bob seemed to feel that he was under a great deal of pressure from the Fellows, from his Clinician, and from home. Most of all, he felt pressure from himself. All these pressures must

have overflowed. When his Clinician touched him on the jaw it may be that he felt he was being manipulated like a puppet or used like a guinea pig, which could easily have intensified his doubts about the genuineness of the Fellows' interest. There are a number of other, equally good, interpretations, and we never achieved a really satisfactory answer. And by not understanding this crisis, if that's what it was, we failed Bob in some degree. The pressures that he was feeling were not pressures we could alleviate very easily. We tried to reassure him, and to counsel him about our motivations. Of course we wanted to help him as well as learn about stuttering, and this point of view was expressed to him. As for the pressures at home and from himself, all we could do was counsel him about how to handle them, give him the best therapy possible, and hope he could handle the pressure.

On Friday therapy resumed in the first morning session. The goal was to locate the point in a repetition where tension built up, and to try to figure out how Bob broke the tension and moved on. This was really a continuation of a therapy session held the preceding day. As a new wrinkle, however, Bob was to try to introduce variation into his stuttering pattern. During this session Bob had two severe blocks, which the Clinician forced him to hold onto and continue until he had used up all of his air. Immediately after, the Clinician imitated these blocks for Bob's benefit. Bob was shocked and amazed at how severe his blocks had been. He felt panicky and exhausted. When asked to review his feelings and behavior during the blocks, however, he did so with excellent understanding. Later, he had two more severe blocks and he got control of them and moved through the word. When asked how he had accomplished this, he said he did it by loosening up when he felt the tension but without stopping his speech movement.

In the videotaped session Bob was asked to vary the number of jaw movements he made as he faked stuttering. During the taping Bob's Clinician asked him "why does the stutterer keep coming back to the first sound?" Bob replied that it was because he knew he wasn't making the *second* sound correctly. When asked how he knew it wasn't correct, he answered that it didn't "feel or look right." He was then asked to move his tongue to the right place, to get the feel of the tongue posture, to move consciously from one position to the other. This was a significant moment, one in which Bob got a clearer understanding of the speech process. The Clinician shifted to another activity briefly, then went back to a consideration of the correct or incorrect sound (coarticulation) and asked Bob to demonstrate the correct movement. This work with coarticulation was leading toward the discovery of a particular behavior, one which Dr. Van Riper had described as the "key log in the logjam of core behaviors." The idea

is that there are a set of behaviors each of which causes fear, which in turn precipitates another behavior which also causes fear, and so on. Bob's Clinician was trying to find the first stimulus in this stimulus-response chain. There was evidence that inappropriate coarticulation was the first event in this case. It was in this discussion that Bob began to voice a theme we heard more of later on, that of feeling helpless.

In the last morning session Bob reviewed what he had learned earlier. He said he learned that there is a point at which he can break out of a block and slow down the tremor.

In the first afternoon session Bob watched a videotape of another stutterer in three different stages of therapy. This was apparently also an important event. While he was watching the tape, Bob's behavior was closely monitored by the observing team member. He seemed to be extremely interested in the stutterer's description of his blocks, his avoidance behavior, and his nervousness in trying to force out speech and hide his stuttering. When the stutterer on tape spoke of his need to overcome the tendency to "jump out of the block" Bob's attention seemed to wander, or perhaps he became anxious. But when the stutterer on tape spoke of the techniques he used to control his stuttering Bob became intensely interested. And when the stutterer mentioned that his speech was his responsibility and that he had to do something about it, Bob's eyes went down, as if he felt guilty or ashamed.

After the tape, Bob was asked for his reactions. He cited the improvement during the three phases of therapy, listed some timers he had uncovered, and noted that the stutterer and he had several things in common, some of which he was not able to put into words. He said that he had learned that a stutterer has to work on his speech all the time but does not want to because he's hoping for fluency. This remark indicated a substantial change from his earlier attitude.

On Saturday night he made a phone call home and reported excitedly to his Clinician that he had been able to move forward through words during the phone call. He also went fishing on Sunday with one of the team members and she noted that while catching a fish, which was very exciting for him, he had rapid tremors and repetitions.

Group Activities

During the first week, a number of activities took place, both formal and informal, which involved more than one of the clients. During the weekend preceding the first week of formal therapy, an incident took place involving Bob and Joe which apparently had

therapeutic significance for both of them. They were exploring the countryside with Joe's Clinician and one of the members of his team when they picked up a hitch hiker. He rode with them for about 30 minutes, on the way to a gas station. All four of them stuttered voluntarily, including the team member, who was not a stutterer. They faked or had real blocks that were quite severe. It was the first experience either of the two clients had had with voluntary stuttering and, if anything, they learned that it is possible to stutter voluntarily with someone you don't know and get away with it. It may have been the beginning of a process of desensitization to stuttering. They also seemed to learn that any experience can be turned into a therapeutic experience; it doesn't have to take place in a clinic.

On Monday the group met for the first time for a formal therapy session. This first session was very tense. Bob showed a great deal of spontaneous fluency and stuttering of diminished severity. Joe made a sincere and successful effort to maintain ongoing speech and did some voluntary stuttering. Allen said very little and used many avoidance and postponement devices. Several times he avoided communicating by changing the subject or by letting someone else answer for him. Eventually they discussed the goals of the group therapy sessions and determined that they could be used for general group support, for stimulation of new ideas, for trying new things, or for reality testing. They also set up some rules for group interaction. The most noteworthy thing about the session was Allen's failure to become involved in the group. This may have happened because Bob and Joe's therapy had progressed far enough, even on the first day, so that they could participate in the discussion, but Allen's had not, and he had little choice but to use his old tricks.

On Tuesday the group talked about the nature of stuttering after having read an article which gave them some basic information. Joe's Clinician was serving as group leader and asked Allen directly why he had not been participating in the group. He replied that "he hadn't given it enough thought," which was one of his common avoidance behaviors. Bob commented several times about how uncomfortable it made him feel that there were observers outside the room, and he tried to get the observers into the room with the rest of the group. He felt that it was stressful to have observers watching him without being able to see them. Later, it was discovered that Bob had not read the article, and he may have been trying to keep the topic of conversation away from it. Generally, there was little actual interaction during the group session.

On Wednesday Joe's Clinician showed slides of people in various attitudes. He told the group that these people were listeners and that the group was to determine if they were listening to stutterers or to

fluent speakers. They all wrote down their answers and later compared them. Allen, it turned out, had not understood the directions. Since feigning misunderstanding might have been an avoidance technique, the leader asked him if he was telling the truth. He said that he was and seemed to open up for the first time. Perhaps he realized that the Clinician saw through his avoidance devices and that he would not be able to get away with them. Later Allen dropped a significant remark. He said "When I don't wish to talk about a subject I don't let myself think about the words to say."

When Bob was asked about the listeners on the slides he wanted to know what the observers outside the room thought before he answered. He had a hunch before viewing the slides that they were either all listening to stutterers or they were all listening to fluent speakers. He chose all stutterers and documented his answers intelligently. Joe was not confident about his answers, but he seemed more relaxed than he had been before. He did give an answer for each slide. It turned out that none of the slides showed people listening to anything; they were people who had been instructed to stand and have their picture taken. This upset Bob. He was sure he had been right and felt tricked. Allen smiled because he had figured out in advance the parable that people read their own perception of a situation into other people's reactions. Joe was pleased because for the first time he wasn't the only one who was wrong. One of the team noted that Joe had a rather slow kind of incoordination in his movement, and someone in a later discussion suggested a neurological work-up. Joe's Clinician vetoed this, saying that it wouldn't change therapy and might lower Joe's carefully nurtured morale.

The group therapy sessions of Thursday and Friday provided too little information to bear reporting.

THE SECOND WEEK

Joe Du Pre

At the Monday morning review session, several of Joe's weekend activities were reviewed. On one occasion when Joe was with his Clinician and another stutterer who was a friend of the Clinician's, the friend had a bad block but was able to handle it and recover from it. The Clinician felt that it had been a good experience for Joe to see that you can break down and put yourself back together again.

Joe's Clinician summarized for the group the current state of Joe's therapy:

> We have all seen a significant change in Joe since July 1. He is talking easier and talking more. He is obviously enjoying it. For the first time in his life, he told me, he can tell others what he is thinking and feeling. At first he seemed to view prolongation as a magical device to stop stuttering. Now, however, he is working through the idea that what he does is monitor his mouth, reject those old stickings and slide through words. Saturday I noted some delay before a block, an audible repetition, and small rehearsal movements. I counted these during a five minute period and noted only five instances. Now we need to give him lots of experience.

To give him more experience, Joe's Clinician decided to increase the linguistic complexity, the time pressure, and the listener stress associated with his therapy sessions. In the videotaped session on Monday, these elements were introduced. While Joe talked about the therapy program and practiced his prolongations, the Clinician asked questions, acted fidgity, looked away, and so on. With these and other techniques, the level of listener stress was built up considerably, but it didn't seem to disrupt Joe's speech. Then the Clinician began to alter linguistic complexity. He asked Joe first to fill in the last words of song titles he knew, then to fill in common phrases, and finally sentences. The Clinician continued to increase linguistic complexity by having Joe tell a story, read a passage, and then take part in a conversation with the Clinician. Time pressure was also increased by asking Joe to list as many foods as he could think of in one minute or to name as many song titles as he could think of while the clock was ticking away. Finally Joe and his Clinician acted out a scene in which the Clinician played a policeman. Not until this final scene did Joe become dysfluent.

In viewing the videotape session, Dr. Shames, who was the Consultant, noted that several different things were being done at the same time. He felt that less confusion would have resulted if only one variable had been changed at a time. He also commented on the

value of observing the client as much as possible before beginning therapeutic management. Thorough observation decreases the chances of early failures. Furthermore, when a trial and error approach is used, the effect of frustration on the client can be substantial.

On Tuesday morning Joe's Clinician introduced the concept of faked stuttering, and Joe seemed to grasp the idea without difficulty. Joe said he thought it would be helpful for him to talk to people outside the clinic. Talking to clinicians all the time, he felt, was not a real enough situation. The Clinician suggested that there might be a step in between, perhaps acting out scenes in the clinic. Joe did not care for this idea; he wanted to be active and not just "sit around and talk." Someone suggested that the team members might act differently – try to frighten him or shake him up. Joe said that it wouldn't be the same. "It's not like talking to a stranger talking to you people." So it was decided to begin working on outside assignments and Joe was given the responsibility for planning them.

At lunch time, Joe decided to place the team's order at one of the local hamburger stands. Joe decided that, in doing so, he would voluntarily prolong the first two words of the order, in the middle he would work through any words he blocked on, and toward the end he would voluntarily repeat two words. With one of the team members, he discussed what might happen, particularly the possibility of failure. Then the assignment was carried out. The girl who took the order was a good listener; she maintained eye contact and didn't get flustered. Afterward, Joe said he had felt a little shaky at the beginning but that it had been fairly easy to start out with a prolongation. The team member and Joe "replayed" the scene several times afterwards. Then they decided they would like a second hamburger and mapped out another plan. Joe decided he would repeat the first word voluntarily and prolong voluntarily on the word *hamburger*. Getting the same waitress again, he carried out the assignment. He said more than once that this was the first time he had worked on his speech "out-side." He did one more assignment, getting change for cigarettes. He planned to prolong the first word and the word *change*. During all these assignments he was to work through any words he blocked on. After lunch Joe and the team member talked about the fact that Joe had requested outside situations. Joe said he had wanted to for several days but had been afraid his Clinician would "kick him out of therapy." After a week of what they thought was very open and honest interaction with Joe, the team members were surprised to discover how seriously Joe had misperceived the situation and his Clinician, although, considering the misperception, they were glad to see him being assertive.

In the videotaped session that morning the goal had been for Joe to carry on a conversation in an area he was familiar with under increasing degrees of stress and linguistic complexity. The procedures were the same as those used the day before. During the taping he seemed to be able to cope with 75-80 per cent of his stutterings. In the discussion after watching the videotape, Dr. Shames noted that he was under a continuous punishment but a partial reinforcement schedule and that this combination might be confusing. Furthermore, he noted that punishment *can* be a therapeutically dangerous procedure and it might be better if there had been no punishment. In any event, the speech clinician working with a stutterer should at least be aware of whatever conditioning procedures are taking place, although it is better if he plans them in advance.

Another outside assignment was designed that afternoon in which Joe planned what he was going to do and demonstrated it to the Clinician before actually going into the situation. The first assignment was to return an article at a local department store. For added stress he did not have a sales slip. He carried it out with great success, both listeners being attentive and courteous. In the second assignment Joe spoke to a male clerk in the sporting goods section of a department store. He exaggerated his prolongations successfully, although he broke eye contact briefly. He then went on a third assignment to the key department and asked to have a house key duplicated, exaggerating audible repetitions and silent blocks. The idea was for Joe to precipitate moments of stuttering voluntarily, at first with extreme tension, then gradually to relax, and finally ease his way out of the block. Many times Joe had said that audible repetitions were extremely stressful to him. Although the speaking situation was fairly brief, Joe was again totally successful in carrying out the assignment and was praised accordingly. He then entered a fourth situation in which he voluntarily used severe audible repetitions and silent blocks. This time the listener was a young girl who became noticeably upset, looked away, and completed his sentence for him. Even after she had completed his sentence, Joe finished the sentence for himself, and stuttered voluntarily on the final word. He then voluntarily entered an unplanned situation and faked stuttering with another female clerk, even though she looked uncomfortable and concerned. Continuing to fake stuttering, he entered several other situations. After four such assignments, they moved from the department store to a local restaurant and Joe ordered a coke. This time he blocked involuntarily on the /k/ in *coke* and had a real moment of stuttering. The team members were not there to observe, but Joe reported that he had worked through the block using

prolongation. In reviewing the day's activities the team members noted that in most of the assignments Joe had been speaking in short sentences and that eventually he would have to plan the assignments so that he can produce longer and more complex utterances.

In another afternoon session, Joe was placed under DAF. Using decreasing amounts of delay and having Joe speak in three modes of communication – reading, monologue, and conversation – DAF was used as one more situation in which prolongation or moving forward could lead to more effective and efficient speech. The preceding day Joe had also been under DAF and had begun with maximum delay. This had a pronounced, positive effect on Joe's speech in the reading mode, a moderate effect in monologue, and no effect in conversation. On this day, delay was set at .33 seconds, slightly less than maximum and, following a practice period, he was observed in all three modes. He did even better, with only a few blocks in all three modes. Joe was then asked to increase his rate and if possible to surpass his rate of the day before. He did so, increasing markedly the number of words read per minute without increasing the number of blocks.

Wednesday, it was decided, would be a holiday, and no work was done.

On Thursday morning Joe went with his Clinician to get a haircut and struck up a conversation with the barber. Unknown to Joe, the Clinician had instructed the barber to pressure Joe a little while talking to him. Joe was told about it later, and felt that he had handled the situation well, faking some stuttering and prolonging. As another assignment that morning, Joe interviewed Dr. Luper, who was the Consultant, and was again successful in faking stuttering and prolongation. He also reported having had two real moments of stuttering in which he had worked through the blocks successfully.

Two of the team members then set up an inter-office telephone situation so that Joe could practice making telephone calls. He had a severe block on the first attempt, and it was 30 seconds before he was able to move through the word. As the team members talked with him, they gradually introduced stress. He blocked several times and had difficulty moving forward on some of them. The team members noted, however, that there were also many instances of fluency and on some occasions the pacing and rate of speech were normal. A tape was made of these conversations, and Joe and the team members listened to it afterwards, the team members taking the opportunity to suggest to Joe that he use the audible repetition in an exaggerated manner. Since Joe did not take to the idea enthusiastically, the team members thought he might need desensitization to it.

That afternoon Joe continued to work on DAF, and the delay

was reduced to .2 seconds. There was a slight increase in blocks in all three modes of speech. This was not unexpected and provided an opportunity to discuss with Joe the kind of daily variation in fluency that might be expected to occur.

On Friday, in one of the morning sessions, Joe's speech seemed greatly improved. The frequency of stutterings was markedly decreased as was their duration and severity. Furthermore, Joe was doing an excellent job of exaggerating the forward movement of speech with prolongation. No glottal fry, no tisks, and no spitting behaviors were observed, and there were only a very few silent lip preformations. One reason for this excellent performance may have been that during the preceding session Joe had been speaking under DAF. It may have helped to give Joe greater movement with greater vocal intensity. During the latter part of the session Joe ventilated some intense feelings about his family. Usually Joe's speech would deteriorate under such conditions, but this time it did not. The implication was clear that Joe should continue working with DAF.

In the second week of Joe's therapy he seemed to have maintained, as if by momentum, the change in morale which occurred in the preceding week. He continued to improve. Perhaps his successes in carrying out assignments and his increased assertiveness in taking some control over his own therapeutic progress, were caused by the increased confidence the team had managed to instill in him during the first week. The gain seemed so great that he may have improved more through recovering from the crisis than he would have if the crisis had never occurred in the first place.

Allen Williams

During Allen's second week he continued his rambling search for an understanding of his stuttering, for a technique that he could use to remedy his difficulties, and for a way to tap the abilities and the information of his team. Here and there, he had a moment of insight or successfully acquired a behavior that enabled him to communicate more effectively, chosen from the noisy background of uncertainty, out of which Allen identified his therapy, performed it, and evaluated it.

In the Monday morning review session, Allen's weekend activities were reported. He had spent much of the time working on his public address. Sunday night, however, he attended a party with his Clinician. There were mostly professional people at the party, and it was a peculiar situation for Allen. (He had earlier suggested being introduced to faculty members as a difficult situation that he should

learn to get into.) He made several attempts to speak, but he was not fluent. Sensing, perhaps, that the situation was really too difficult for him at this stage of his therapy, he had not made a great effort to talk. On several occasions over the weekend he had asked some of his team members how to pronounce words and had inquired about what they meant. He had trouble saying *therapeutic, clinician,* and *irrelevant.*

Allen had been asked to have some short term goals ready for the first session on Monday, and he presented the following:

1. To learn how to get into and out of a block.
2. To eliminate all of my long repetitions.
3. To start getting feedback on day to day improvement of my short repetitions (and long ones if they occur).

Allen talked about how difficult it had been for him to contribute to the conversation at the party Sunday night. He said "I should have had something to say, and I wanted to say something, but my mind seemed to draw a blank." Since Allen seemed to have run out of information to report, the Clinician outlined his own short term goals for Allen:

1. To successfully deliver his assignment in the public address class.
2. To be able to precipitate voluntarily an involuntary tremor and to be able to modify it.
3. To be able to produce voluntary syllable repetitions without arousing anxiety in himself or his listeners.

The Clinician said that he expected these goals to be accomplished by Wednesday. Since Allen didn't comment on this set of goals, the Clinician decided to go on to a new topic and introduced the technique of pulling out, which Allen would have to learn how to use in order to achieve the second of the Clinician's three goals. After a brief discussion, it was evident that Allen needed time to digest the concept of pulling out, and the subject was set aside.

Allen's Clinician then presented a fluency analysis of a tape made in an earlier session. Allen had had no word or phrase repetitions, only a few rapid syllable repetitions (all on the word *I*), and a dysfluency rate of 6.5 per cent, which was within the range for college normals. The *type* of dysfluency, however, was not typical of normal speakers. A discussion of dysfluency types followed, in which the Clinician stressed the distinction between normal nonfluencies and stuttering.

In the videotaped session that morning, Allen and his Clinician spent the entire session learning pull-outs, and Allen found it difficult to achieve a relaxed pull-out. With consistent practice, however, he achieved some improvement. The Clinician then tried to

engage Allen in conversation so that he would have the opportunity to pull out of some real blocks, but Allen was fluent. They concluded the session, noting that situations of greater difficulty would be required.

In the next session instruction in the use of pull-outs continued. The Clinician described pull-outs as moving from the blocking position, whether silent or oscillating, to a conscious recognition of what that position is, and slow, careful, consciously controlled movement, to the next articulatory position. Ultimately, he said, the client develops an automatic response that replaces the pull-out and becomes condensed in time. Some specific suggestions concerning pulling out of silent blocks were given, since this type of blocking was a common part of Allen's speech.

In the first afternoon session Allen practiced the speech that he was going to give on Thursday. The topic was what it felt like to be a stutterer, and although Allen was well informed on the subject, his ability to compose a speech was very poor, so the team member helped him in clarifying points and organizing material. Allen then presented the first version of his speech, but it did not come off very well. He was anxious during the presentation, realizing that he had not prepared enough information to talk about and that he did not have his ideas clearly in mind. During a one minute sample, he had seven repetitions, accompanied by overt secondary behaviors. Allen decided to rewrite the speech and give it again during the later afternoon therapy session when all the members of the team would be present.

After working on his speech for a while, Allen and his team got together again. First he reviewed the outline of his speech and then he delivered it. Afterwards, he said he had given the speech without too much awareness of what he was saying. After the team made a few suggestions, Allen decided to work further on the speech, but at a later time. For the rest of that session he wanted to work on pull-outs, so, using the first part of his prepared speech as material, Allen practiced pulling out of tremors. He found it difficult to reduce the tension, and the Clinician suggested he analyze the tremor to see if he could find the source of tension. He was given the specific instruction to learn "to pause and think without tension." Following these instructions, he became suddenly fluent, and the topic of conversation was quickly changed so that his dysfluencies would increase. Toward the end of the session he began to use the pull-out in a more controlled manner.

Allen seemed to have more difficulty than most stutterers learning how to pull out of a block. This difficulty may have been related to some of his more general personality traits. The Fellows had com-

mented that Allen dealt with stressful situations either by withdrawing completely from them or by trying to dominate them. There was very little moderation in his communicative behavior. Pull-outs require him to take a moderate, easy approach behavior, and this may have been one reason he found them hard to do. His difficulty may also have centered around the fact that his predominant stuttering behavior was silent blocking. When pulling out of an audible block there is an acoustic change as soon as the tension is reduced, telling the stutterer that he is on the right track. In a silent block, however, tension has to be reduced considerably, almost completely, before the vocalization begins and the stutterer gets feedback about the correctness of his attempt.

In the morning review session on Tuesday it began to be clear that Allen's address to the public speaking class was becoming a trauma point. No one was certain how concerned Allen was about giving the speech, but his team members and the rest of the Fellows were beginning to worry that it might be a bad experience for him. As a result, his Clinician was spending more time helping Allen, who found it difficult to prepare a paragraph – he didn't know what to say for more than about a minute at a time. Giving the speech was another example, it seemed, of Allen's tendency to set goals that were too high for him, at least in communicative situations, where he didn't perform so well.

In the first morning therapy session, he practiced delivering his speech as he had prepared it up to that point. Perhaps, a team member suggested, Allen could demonstrate his stuttering during parts of the speech rather than just describing it. With some reluctance Allen accepted the suggestion. He then gave the speech twice, once without referring to his notes. It proved difficult for him to sequence his ideas, and several times while trying to remember he laughed with embarrassment and gestured that he was lost. At the end of the session, the Clinician suggested that Allen write a complete outline of his speech and deliver it during the videotaping so that he could monitor his performance afterwards.

For the videotaped session, Allen's team sat in the room and acted as an audience while he gave his speech. He had a number of dysfluencies, mostly syllable repetitions, but he was also successful in modifying some blocks and stuttered on purpose two times. As they watched the videotape that afternoon, some of the Fellows were afraid Allen might be doing too much too soon. Or, they thought, he might, for some reason, be setting himself up for punishment. Another suggestion was that under the extreme fear of delivering the address he would be fluent. Others, however, thought there had been too much concern about the speech.

In the first afternoon therapy session, Allen gave his speech again and practiced pull-outs while doing so. Again he had difficulty monitoring his tremors whenever they were inaudible, and an effort was made to "bring the blocks out in the open." The first time he gave the speech he used pull-outs about half the time. The second time he gave the speech the Clinician stopped him each time he failed to use a pull-out, asked him to go back and use the pull-out, and then analyzed his performance. Under these circumstances, he used the pull-out on about 90 per cent of the blocks. On a third delivery of the speech he had only four blocks and didn't use pull-outs on any of them.

In the second afternoon session, the dual goal of better pull-outs and better public speaking was pursued again. This time, after the Clinician had spent most of the session explaining some of the details of pull-outs, Allen gave his speech again. It lasted about seven minutes, and he was quite fluent. When asked why he was so fluent, he said "I'm thinking of clear speech so I don't block." In this speech, language formulation and processing were also easier for Allen than they had been two days ago. This confirmed the Clinician's hypothesis that the difficulty in formulating language acted as a noxious stimulus which led to blocking. Allen then delivered the speech once more with the videotape running and the entire team listening, and he had approximately six repetitions in a one minute sample. Afterward, he watched the videotape and worked briefly on pull-outs before going home.

Wednesday no work was done.

In the Thursday morning review session Allen's Clinician reported that the night before Allen had come to his cabin in order to rehearse his speech. While there, Allen reported that he had learned how to change his set, by faking stuttering enough so that he would have no real blocks. This report prompted a discussion among the Fellows of Allen's tendency to dominate situations. Perhaps when he controls situations or dominates the approach to communication he is using an avoidance technique. It may be that he is most dysfluent in situations in which he is submissive and by dominating a given situation he can avoid placing himself in such a posture. Allen's Clinician said that if this were the case, Allen would have to learn how to identify it and deal with it as an avoidance behavior.

Thursday was the morning of Allen's speech. He was scheduled to address the public speaking class at eight o'clock, and, needless to say, his team was eager to learn how he would do and concerned that he not have a humiliating experience. Also, the speech represented a

critical point in the therapeutic process. If he should fail, it would clearly be a setback, although perhaps one from which learning could take place. If he should succeed, therapeutic management would have to be delicate from that point on to avoid having Allen place too great an emphasis on the behaviors that he had used during the speech. The reinforcement of a successful public speech would be very great, and the behaviors that preceded it would be strongly reinforced. But those reinforced behaviors might not be the best behaviors for Allen to use on a permanent basis. Of course, the experience might turn out to be entirely successful – a good speech, and an experience from which therapy could progress forward.

His team was waiting attentively when Allen returned from the class. He seemed to be dejected. He did not smile, and his eyes were downcast. He said "Hello" somberly, and the Clinician asked how things had gone. Allen replied "I had a severe stuttering flashback [sic]. The speech didn't go too good." Allen went on to say that he had not been able to give the speech, that he could not even start it. "What did you do?" the Clinician asked. To answer, Allen said he wanted to play the tape he had made of the speech to the group. Unfortunately, the tape was poor, and it was difficult to hear Allen's attempt to give his speech. This was not what Allen had planned, and he had to tell the team that the speech had actually gone very well and he had had no actual breakdowns. He smiled broadly and sat back to watch the team's reactions. Someone dropped his notebook on the floor, and they all started talking at once as they realized that it was a joke and that the speech had actually gone very well. The public address instructor had rated his delivery above average, in fact he thought Allen had been sent over to the class on some kind of an assignment, implying that he didn't think Allen was really a severe stutterer.

Allen's report to the team was another example of his startling ability to control situations. It was also an example of a humorous technique he had used previously for achieving control – saying the opposite of what he really intended to communicate. (In one of the earlier group therapy sessions, Allen had told the presiding clinician, in an attempt at humor, that he was a "lousy clinician." Shortly afterward, he had retracted the statement and complimented him.) Maybe Allen's joke on his team had no more importance than any other joke; that is probably all it was. But perhaps he perceived in advance that it would be difficult to tell his team, while they waited breathlessly for a report, that his speech had gone very well, better in fact than anybody expected. It was also a situation in which he *had* to communicate. If he had indeed anticipated this as a difficult communication situation, he might have avoided it by turning the

tables and telling the group the opposite of what had happened.

After the uproar about Allen's joke had died down, he and the team discussed the speech. Allen said he knew he had been anxious because his knees were shaking, but he had controlled his speech, so no breakdowns occurred. At one point in the speech he was to imitate severe stuttering. On this occasion, he accidentally put himself into a real block but had no difficulty in going right into fluent speech. To bring things into perspective, the Clinician asked Allen where he saw himself going from this point in therapy, and Allen replied that it would be difficult to find a situation he would stutter in, but that he still had a language formulation problem. Consequently, he wanted to find harder situations, ones in which he would stutter, and he wanted to work on language formulation. The Clinician also asked Allen if he felt that he wanted to be a fluent speaker, if he could identify that desire. Allen said that he could. Was that feeling strong enough to cause tension, the Clinician asked. Yes it was, Allen said. And although he could exercise some control over his tension he thought he ought to be able to do it better. He did feel, however, that he could control the blocks.

On Friday Allen's Clinician reviewed the therapy situation for the team. "Ideally," he said, "I'd send Allen home for a month now. He'd find out which parts of his problem have not been solved and would then come back to work. At a certain point there needs to be reality testing." Allen then reported on a political discussion he had had Thursday night with one of the Fellows who was a member of one of the other teams. He had gotten excited and had a couple of repetitions and some silent blocks. He said, "I hadn't been thinking about my therapy at all and my speech was much worse." He also reported having had some difficulty talking with a friend of his at dinner earlier. The team then discussed these breakdowns, analyzing the emotions that were involved and the events that had preceded the blocks. It seemed odd that Allen had had so little difficulty delivering a speech to a class early on Thursday and then so much difficulty in a conversation later the same evening. The Clinician said that the skills he had used in giving the speech were still new and that when he put himself in a situation without consciously working on them, the new habits would not be strong enough to take over, and the old habits would come back. He advised Allen that what he had to do was to keep working on his new skills long after he was first successful with them. When asked to analyze where he was in therapy, what skills he might need, and how to learn them, Allen outlined six points. (1) "When I get the feeling of stuttering, I stop, think, relax my muscles, and go ahead and say it (a preparatory set).

(2) Pull-outs – I haven't used them very much. (3) Language formulation skills – I work on this all the time in both informal and formal circumstances. (4) Initiating communication in situations. (5) In the group therapy session, I learned to stutter on purpose and to control my stuttering. (6) Changing my mental set, for example trying to stutter because you want to rather than because you are trying to be fluent." Allen's Clinician, noting that Allen was having more normal nonfluencies than he usually did, asked him to analyze those nonfluencies on the tape. Allen's Clinician then announced a fifteen-minute break, during which Allen was to organize all of the six points he had mentioned before and come up with a therapy plan for them. After five minutes or so, he said he had no idea how to begin planning. He was told to try again; the team would help him polish it up afterwards. Eventually, he came up with some situations in which he could practice. In the discussion that followed, the Clinician tried to sharpen Allen's awareness of where he was and what he was trying to do. Particularly, he wanted Allen to set goals that were more specific because he would get more from therapy if he did so. Allen continued working on his outline, with the team's help, until the end of the session.

That afternoon a reporter from a local paper came to the clinic to gather material for a story on the Institute. One of the things she wanted to do was talk to the clients, and her interview of Allen seemed like a good opportunity for him to place himself in anxious sets so as to precipitate tension and tremors. This would give him an opportunity to use preparatory sets and pull-outs. During the interview, Allen had a very difficult time initiating phonation on one word and showed a great deal of struggle behavior, but he appeared to carry out the predetermined goals of the session more easily from that point on.

In the first afternoon therapy session on Friday, Allen was asked to write up a description of the newspaper interview he had just completed. After finishing, he asked about the pronunciation of the word *idea*. It became evident that he did not discriminate between *idea* and *ideal*, and the team member did some discrimination drill with him. Allen was extremely fluent in the second part of the session, during which he read aloud from a newspaper.

At the end of the second week, Allen seemed to have gained some more focus and direction. He had gained facility in using pull-outs and preparatory sets. Certainly, he was much more fluent. And he had successfully delivered a public address. He was still rambling, but he was rambling with somewhat more direction toward a more specific goal.

During the second week of therapy, Bob's Clinician continued to have him analyze individual blocks and give him an opportunity to ventilate his feelings. It was during this week that the Fellows began to get a better idea of Bob's personality and its relationship to his stuttering. Toward the end of the week a significant change in his behavior was seen.

Bob's Clinician announced his goals for the week, as follows:

1. Find the core behavior and identify the proprioceptive cues that initiate struggling and avoidance.
2. Find out how he initiates and ends blocks and determine the role played by word length, vowels, blends, and consonants.
3. Find the postures that trigger stoppage of phonation.
4. Teach him to vary his tremors and bridge his vowel sounds.
5. Introduce cancellation.
6. Increase tolerance to failure.

In the first session Monday morning, Bob worked with one of his team members on an assignment to identify and analyze his tremors on three specific words which his Clinician had selected. On the first word, he had difficulty making the tremor feel real, and also reported that his jaw hurt during the faking because his new found fluency had allowed his jaw to "go soft." On the second word he began faking a tremor and found himself in a real block. He noted that the real block occurred on a particular sound combination, which he inserted before he produced the first sound of the word. Continuing his analysis of the tremor, he discovered that it had two parts, a simple tremor phase, which occurred first, and a second phase of larger jaw oscillations and jerks. He reported that he was stuttering more than on the preceding day and wasn't sure why.

The goals for that morning's videotape were as follows: (1) locate the ways Bob's stuttering is initiated, (2) determine how he moves away or recoils from stuttering, (3) determine what tightens him up, and (4) increase his tolerance of failure. The procedures to achieve these goals were the same as they had been for the past few days – close analysis of specific blocks. The Clinician planned, however, to interrupt frequently and to be more demanding, not allowing Bob to skip the small blocks. As these procedures were carried out, Bob seemed to be bored, yawning and scratching, so the Clinician terminated the session early, which visibly shook Bob. He asked why, but was given no immediate answer. This was the beginning of a week-long attempt to get Bob to take a more direct responsibility for his own therapy.

Watching the videotape that afternoon, the Fellows noted that although one of the goals was to get Bob to accept responsibility for his stuttering, the Clinician occasionally lapsed into animistic language ("What's your jaw doing?").

In another morning session, Bob and some of his team members tried to find core behaviors that initiated his struggle and avoidance. As another goal they tried to locate postures triggering tremors and stoppage of phonation. By increasing the speed of his jaw movement, Bob found, he could elicit more fear, which in turn would set off struggling. He also found that when he extended his jaw in a certain way, he tended to "go into a big block." After the session the team member thought Bob had not been totally involved and was not giving a maximum effort to achieve the objectives. Later in the afternoon, he showed a similar detachment in the group therapy session.

An individual therapy session held that afternoon was designed to intensify Bob's awareness of proprioceptive feedback for speech. To achieve this goal Bob tried to "beat the DAF machine." At first, the device was set at the delay time which had previously been found to cause minimal disintegration of Bob's speech. Gradually, the delay time was increased, but Bob managed to maintain well integrated speech. At the end of the hour Bob reviewed his experience with DAF. He said that at first he had been very confused and had spoken very rapidly. Now, with a slow rate and careful monitoring of speech movements, "it doesn't throw me so badly."

Tuesday morning, Bob met with one of his team members in a session designed to elicit from Bob a description of his reaction to feared words, first what he felt as he anticipated the word and then what he did to cope with it. As a secondary purpose, the team member was to increase communicative stress during the session. Bob began by describing what he called a "conk-out." He described it as "the most fearful of things that happen to stutterers." During a "conk-out," he holds his breath, his eyes are blurred, he has little knowledge of what is going on around him because he can't see well, he is in a mental block, and his tongue is "dead" and unmoving. Good as his behavioral description was, he was not able to analyze very specifically what his feelings were like before the conk-out. As for the tremor, he gave a close description of it but in an intellectualized and superficial manner, describing it as "the second most feared by stutterers." The description itself seemed straight out of a textbook, and it was clear that Bob had been doing some reading. It was remarkable, however, how well he had retained and understood the concepts. Since Bob was using proprioception and forward movement during his speech and was generally in good control, the team member took steps to increase communicative stress, increasing the

intensity of her voice, taking notes, asking for clarifications, and looking puzzled. Bob increased the intensity of his voice, fidgeted, sighed, and tried to change the subject – but he did not become more dysfluent.

In Tuesday's videotaped session Bob was to prolong and move deliberately through each word. Whenever he used a postponement or timing device he had to write down the word and the nature of the threat that had caused him to use the device. Bob carried out the assignment perfectly, moving deliberately through every word. He also discussed his awareness of slowing down, of feeling the word, and of moving through it. On one word, he compared a pull-out, normal fluency, and a hard contact, experimented with different ways of saying the initial sound, and analyzed how to loosen the phoneme. He also identified one of his threatening situations – when people ask him to repeat by saying "What?" In this session, Bob made an important discovery. He found that he could signal, by raising his finger, at the moment when he was able to shift out of a block into the rest of the word. Analyzing that brief moment, he noted that a lack of tension and a feeling that his tongue was in the correct position were the signals which told him he was ready to move on. He also said that he felt "set up" for the second sound. As the therapy session continued, the Clinician demonstrated how to slow down tremors and move on to the next word, and Bob made some further analyses of his speech behavior.

Watching the tape that afternoon the Fellows commented that Bob's Clinician was picking up some extremely subtle aspects of Bob's speech and that the prolonged speech was making Bob much more intelligible. Despite the obvious success of the session, they thought Bob was getting bored with the repetitive nature of therapy.

In the second morning session Bob talked with his team as a group while practicing three activities: (1) moving through the word with energy and deliberation, (2) sticking with the block long enough to hunt for the bridge to the next phoneme, and (3) cancellation. During most of the session he was fluent and seemed to be enjoying the topic without carrying out his tasks.

In the afternoon session Bob spoke under DAF. At first the delay time was set at .23 seconds, and he had some repetitions and prolongations at the ends of words. When the team member changed the delay time to .30 seconds, his phrasing became more rapid and occasionally he phrased his sentences in spurts. If he spoke slowly, however, he did not "get stuck" at this setting. Reverting to a delay time of .23 seconds, the team member asked Bob to make an effort to speak precisely, but he continued to speak in spurts. Afterwards Bob noted that he had not done as well that day as the day before;

he thought he had reverted to some of his earlier strategies in trying to beat the machine.

A number of events occurred at this time, outside the formal therapy setting, which increased our understanding of Bob. On Wednesday, which was a holiday, Bob asked one of his team members to go fishing. When she refused to go, he wheedled, teased, and begged and was not satisfied with the suggestion of going during the following weekend. Bob had previously mentioned that this team member reminded him of his sister, and it seemed likely that his childishness with her was an indulgence in behavior patterns that he used at home. At any rate, these tactics did not work, and he stayed to talk with her. She felt that Bob was becoming more relaxed and natural in his behavior – he was freer to be petulant and demanding, at least with her and some other team members. Although he was clearly demonstrating a greater ability to detect and analyze his stuttering behavior, and could use some of his assignments quite successfully, he still forgot about it whenever he could. He had clearly been bored with therapy during most of the preceding day. This seemed to suggest that he was still more motivated to please his Clinician, or perhaps to prove something to him, than to improve his speech for his own purposes. He may have understood intellectually the need for these activities but he did not seem committed to them. This difficulty in attaining a motivation for his own sake was consistent with the fact that he was highly directed toward gaining the approval of others. His sense of self seemed undeveloped and his awareness of his own needs at a low level. Toward the end of the week, however, Bob's behavior began to change in the direction of more maturity and he showed less evidence of a need for approval.

On Thursday Bob had a session with a team member in which he was supposed to voluntarily precipitate genuine tremors. Despite the fact that the team member had been kept unaware of the assignment, Bob said that he had not been able to achieve genuine tremors because he was talking to a speech clinician and "you know what I'm doing."

In the videotaped session of that day, the goal was to work on the tremor – how to get a real one started, how to end it, and how to vary it in amplitude and frequency. The purpose of analyzing the tremor was to battle the anxiety and the fear during the block itself, to find the direction of the second sound, and then to move forward. With the videotape on, Bob and his Clinician worked on several words, analyzing tremors. Bob continued to be highly fluent, and it was difficult to get a real tremor to develop so that most of the analysis was done with faked tremors. The session was not particularly successful for this reason

After watching the videotape that afternoon, some of the Fellows thought Bob's Clinician had been too quick to tell Bob what he was doing and thinking. Others, however, defended the Clinician's strategy, suggesting that it might be desirable for a number of reasons: to give Bob the feeling that he was understood, to show him that he couldn't get away with anything, to help him discriminate the real from the faked tremor, or perhaps simply as a direct use of suggestion.

In the second morning session Bob concentrated on feeling what happens at the point when voluntary movements become involuntary, when he begins to move into the wrong vowel from the consonant, and what he can do to modify and correct his speech behavior. This time, the Clinician noted that Bob was beginning to get more involved in the therapy, and he seemed to be taking on more responsibility for the control of his stuttering.

In the first session on Friday Bob was to demonstrate that he could "get hold" of his little tremors, that he could continue them past their normal length, slow them down, and move on through them without blocking. He had 22 blocks during the session and failed to follow through correctly on nine of them. After each failure, he went back immediately and corrected himself.

The major objectives for the videotaped session that morning were for Bob to learn to resist frustration, and to make deliberate attempts to deal with his stuttering through proprioceptive monitoring rather than to try to speak fluently. He worked with two team members. One was assigned to ask questions and make sure Bob kept to the subject. Another was to provide communicative stress, which Bob had been instructed to resist. The first team member asked Bob to name some of the situations in which he felt communicative stress. When he mentioned one, the team member encouraged him to explain what it was about the situation that created stress. As he did so, the second team member asked a series of probing questions. At first Bob replied, but when the team member probed further he said "I don't know. It was stressful. That's enough for that one. That's enough!" It was clear that Bob absolutely refused to discuss the matter any further. Although this behavior may have seemed petulant at the time, in retrospect, it was probably the beginning of a change of attitude in which Bob would take on more responsibility for his speech and for his therapy.

After a moment, the first team member went on and asked Bob to name other stressful situations, which he did. When she asked him to talk about the frustration he feels when someone asks "What?" he complained that people do not listen when he talks. The second team member asked if there might not be a legitimate reason for asking

someone to repeat. And Bob replied, "Sure, but they *could* pay better attention." The second team member pursued the question further, and Bob became more involved than he usually did in the process of analyzing his own behavior. He also withstood successfully several attempts by the second team member to raise the stressfulness of the situation. The first team member asked how it felt when people didn't pay attention to him, and Bob said that he clammed up, but if a person was polite and listened, "I don't let them get away from my stuttering." One type of listener that Bob found particularly difficult was the one who took an "oh you poor kid" attitude. "They seem to think you're helpless – like in a grocery store where they tell you where everything is. I don't want to be shown. It makes me feel helpless."

After watching the videotape that afternoon, the Fellows discussed Bob's feelings of helplessness and his childish behavior. As far as the childishness was concerned, one of the Fellows thought Bob might really be asking to be reprimanded, testing to see if we cared enough to punish him. Another reported that Bob had been very fluent when talking with the Fellow's son, in which Bob had played a very authoritarian role, but he had been very dysfluent afterwards when the Fellow reprimanded him for being too bossy. Perhaps, as with Allen, Bob found being the submissive communicator a particularly stressful situation. His way of coping with it may be to throw himself on the mercy of the dominant communicator by playing the part of the child. In other words, he says "You can't hurt me. I'm just a helpless kid." Then, of course, he doesn't like being made to feel helpless. Whether this analysis was correct or not was not certain. It was certain, however, that Bob would need to understand the dynamics of his stuttering if he were to make permanent gains.

During the group therapy session that afternoon Bob spoke of what he felt he had learned. His thoughts are partly a parroting of what his Clinician had told him or of what he had read, but they also show the beginning of some real awareness:

> It's possible to speak without struggle. I found what it was that I was afraid of. I was denying stuttering to myself, but I didn't know it. I was hiding it from others, and not letting it out in the open. I've learned what I do when I stutter. I've become more desensitized – before I was afraid to look at my stuttering, now I look at it without backing away as before. I've learned about different parts of stuttering – tremor, conk-out. The main thing – I've learned about myself. What I need to learn in the future – scan ahead and pick out words that I think I'll stutter on. My goal is fluent stuttering. I'd like to learn more about myself and what I'm afraid of and why I began to stutter, and I guess you find out by analyzing the conk-out.

In the same session, Bob also voiced some feelings of anxiety about going home. He was afraid people would say "Let's see what you have learned." He would feel "like a side show." He talked a little bit more about what he would do to cope with this, and seemed to anticipate it in a mature way.

In the individual therapy session that afternoon, Bob spoke under DAF. As the delay time was decreased, he became less able to maintain proprioceptive monitoring and increasingly dysfluent. He also seemed tired and depressed, but when the team member suggested that the session be terminated he wanted to continue. They worked for a while longer, and when the team member again suggested that they end the session early Bob agreed, but on the way home he complained that they should have worked the whole hour.

The second week of therapy, like the first, represented a kind of crisis or turning point in Bob's therapy, but of a quieter sort. He began to taste some of the boredom and repetitiveness of the work he must do. He resisted a little, by being petulant and by trying to escape into topics of conversation that were more interesting, but his feelings were always ambivalent. As bored as he was, he still wanted to work. Although his drive to do therapy in order to gain approval from those around him was diminishing, his desire to work for his own sake didn't always grow at the same rate. As a result, he found himself occasionally just going through the motions, uninterested, or resisting.

Group Activities

In the first week, the group therapy sessions had not been very successful. Even the clients wondered whether they had any value. After all, group therapy ordinarily serves the purpose of bringing stutterers together so that they can discover that some of their problems are shared by others. These three stutterers were crammed into a small trailer, which presented plenty of problems in itself. If there was one thing they didn't need it was "getting together," or so it seemed. Throughout the second week, the group sessions continued to be a search for their own raison d'etre.

On Monday, Bob's Clinician, who was the group leader for the week, talked at some length about being a stutterer. Joe listened with great interest. Allen participated rarely and asked, toward the end, that the Clinician talk less and let the clients talk more. Bob was quite uncomfortable during the session, perhaps because it was his Clinician, with whom he had shared many confidences that he did not want reported, who was in charge of the group. Several times he seemed to avoid a discussion of feelings, changing the subject to the

mechanics of speech therapy. Perhaps also to avoid meaningful statements, Allen suggested several times during discussions of feelings that they talk about what is "wrong with the Institute."

On Tuesday, they decided they would talk about the Institute and their feelings about it. The leader said he felt as if he were in a goldfish bowl and asked if they felt similarly. They agreed but with little conviction, although they had voiced concern about this problem early in the first week. During this session, Allen used a peculiar phrase. It was a phrase no one had ever heard him use before, but one which his Clinician used frequently. Was Allen modeling his language? Later in the program, the Fellows noticed that Bob was beginning to sound very much like his Clinician, although in the manner of his articulation rather than in his language. For Joe modeling played a minor role, perhaps because the life styles of client and clinician were so dissimilar. Probably inevitable anyway, modeling may be a helpful, perhaps even a necessary, aspect of therapy. But it may also hinder re-entry and carryover. What happens to modeled behavior after the model is no longer around? We had no answers to this or similar questions. But we wondered what effect modeling would have on therapy.

In the group session on Tuesday no group effort developed, and each client took turns doing individual therapy with the leader while the others watched. At the end of the session the clients resolved to bring a topic of discussion to the next group therapy session, which would be on Thursday, since Wednesday had been declared a holiday.

On Thursday, the resolution to bring a topic had apparently been forgotten – at least it never came up. The leader introduced as a topic the technique of scanning for upcoming blocks, preforming the sound that follows the feared sound, and then moving into the word. After demonstrating how to mouth the second sound of the feared word, the leader showed them how to move fluently through the feared word. Allen and Joe had difficulty in identifying what the second sound actually was, and the leader made a brief phonetic analysis of the words in order to clarify the sequence of phonetic events. Both Bob and Allen had difficulty isolating only one phoneme as the second sound, but with prodding they were successful.

On Friday Joe was absent carrying out an assignment, but Bob and Allen, in response to the leader's question, spoke about the progress they had made. Bob's answer has already been given in the section concerning his therapy. Allen said that he had learned to use pull-outs, preparatory sets, and how to formulate thoughts. He said "When I go back home, I will be a fluent speaker and won't have to

think about stuttering." No attempt was made to counsel either of the clients in this session, the purpose being simply to give them a chance to ventilate feelings.

THE THIRD WEEK

Joe Du Pre

Over the weekend between the second and third weeks, Joe, his Clinician, and two team members went to his home town to work with him in the surroundings he would return to at the end of the summer. Joe assisted in planning each assignment and then with one team member at a time went into each situation. Following each experience, he was told how he had done, and he reported to the team his reactions and those of the listeners.

In the first assignment Joe was supposed to watch while his Clinician stuttered to a sales clerk and the two team members followed behind and asked "What was the matter with that man?" The sales lady, however, knew Joe and greeted him halfway through the encounter, so the plans were hastily scrapped. Joe talked with her, though, using prolongations, and did very well.

The most successful assignment was one in which Joe talked to a clerk in a clothing store, using his prolongations to work through blocks. He asked a lot of questions and answered some that were fired at him pretty rapidly. He felt very good about the assignment afterward.

After a few more assignments Joe invited his Clinician and team to meet his parents. They drove out to the Du Pres' summer home, a trailer on a lake. Joe seemed to get tense as they approached the lake. When asked what he was thinking, Joe said he was trying to remember the last name of one of the team members so that he could introduce her to his parents. When they arrived, only Joe's mother was home, and she said right away that Joe seemed much more relaxed, and his speech "easier." She talked about how hard he used to struggle and how she always thought that if he could just slide through the words somehow instead of forcing, he would be better off. Accurate as her analysis may have been, her advice took the form of telling him to slur his words or talk rhythmically. Joe's Clinician explained that he was aiming for an easier pattern and that Joe would not get rid of his stuttering but would learn an easier way to move through his words.

Joe said later that his speech was much better than it had ever been with his mother, and that he spoke more than usual too. The Clinician felt that Mrs. Du Pre was a potential source of reinforcement for Joe's new speech patterns and that a good relationship with her would be a valuable aid in re-entry and carryover. It would help even more, he thought, if the Du Pres could come down to Marquette.

Joe reported on Monday that he had done more assignments in his home town on Saturday night. It was getting to be "fun." Going with his girl friend to different stores, he tried to teach her his old pattern and tried to get her to fake stuttering, but she didn't feel that she could.

For the third week of therapy, Joe's Clinician set a number of goals. First, he wanted to stress desensitization. This meant putting Joe in a number of different situations, asking him to wait before answering, and subjecting him to other kinds of communicative stress. Futhermore, Joe had to learn to do voluntary audible repetitions. A supplementary route to desensitization was the use of humor and disinhibited behavior. A second goal for the week was to reduce Joe's abnormal presets down to as near zero as possible. A third goal was the continued practice of prolongations, particularly moving from a tense posture to a smooth release, with a variety of linguistic and phonetic material. Basically, Joe's Clinician wanted him to get the feeling of being able to cope with those stickings that used to cause him so much stress. The fourth goal was to encourage self-therapy as much as possible. As a fifth goal, another visit to Joe's home town was planned for Saturday.

In the first morning session Monday Joe spoke under DAF with a delay time of .06 seconds. In all three speaking modes he had fewer blocks than on any of the previous DAF sessions. He read for several minutes with complete fluency and carried on a conversation of considerable length, stuttering only a few times.

The videotaped session for Monday was done only to get baseline data for the week and was not shown to the group. Joe read a paragraph, told a story about a series of pictures, and then recounted a previous experience. On the last task, a team member introduced stress by ignoring him, interrupting him with questions, and challenging him about points of information. Lip preformations, starters, spits, tisks, silent blocks, glottal fry, and repetitions were counted.

In the second morning session, Joe and two team members went out on assignments. Joe needed a new fan belt for his car, and the assignment was built around buying it. First, they role-played the situation on the inter-office telephone. Then Joe decided that, using prolongation and faking just a little, he would call up the auto parts company to see if the fan belt was in stock. The conversation went well, even when he was actually under some real time pressure. Joe faked audible repetitions a little, but he showed reluctance, if not resistance, to using them. He was well satisfied with the prolongation technique. Accompanied by two team members, Joe then went down to the auto parts company. As it turned out, Joe had little opportu-

nity to initiate as much conversation as they had planned, and they decided that in future assignments they would have to plan things so that Joe carried more of the conversational burden.

Several members of Joe's team commented in the review session the following morning that he had been reluctant to fake audible repetitions. This was the first hint that Joe might be losing some of the momentum he had achieved after overcoming his crisis in the first week. He was too satisfied with his current improvement. The team felt that he could do better, and they decided to increase the pressure a little. Curiously, some of the same thoughts must have been going through Joe's head, for the next day he put the pressure on himself.

In the videotaped session Tuesday morning, Joe was supposed to interview a 58-year-old school teacher, who was attending the University during the summer session. He overslept and arrived just in time to hear that his job was to take charge of the interview, while faking audible repetitions. He had no time to plan for it, but sailed into it and carried out the assignment with success, even though there were some highly stressful moments – painfully long silences under the camera's unrelenting stare when no one could think of anything to say. He reacted to these moments with more frequent stuttering and less modification. After the interview Joe's self-evaluation was favorable – he felt, rightly, that as the session progressed he had done an increasingly better job of wading through moments of stuttering. At the end of the session, while talking with the Clinician, his speech was strong and spontaneous with much real fluency and skill at working through moments of stuttering.

After the videotaping, the plan was for Joe to go out on assignments with two of his team members. When asked what he felt was important in terms of the future direction of his therapy, he said he thought he should learn how to fake audible repetitions without being afraid of their turning into real ones. The three of them then decided to find some difficult speaking situations in which Joe either was to fake stuttering with his old pattern or use part-word or whole-word repetitions. He was not to be fluent. If he should get into a bad block, he was to let the tension subside and use prolongations to move forward.

The first situation occurred at the Housing Bureau of the University. Joe pretended that he was a student, a Freshman, asking for off-campus housing, although, according to the rules Freshman were supposed to live on campus. He had to give a number of specific items of information, such as his name, address, social security number, and age and explain why he wanted to live off campus. Of course, the University had no record of his status, since he was not

really a student. This created a number of difficult situations, but Joe handled them well, generating plausible answers to probing questions, withstanding time pressures, faking some easy stuttering, and using some exaggerated prolongations. He felt very successful afterwards.

The team members and Joe then went to the snack bar of the student union. Joe decided to go around to various tables and ask people who their favorite folk singer was and why. Visiting four tables and spending about five minutes at each one, he kept all of the conversations going and obviously did more talking himself than was necessary. He showed a surprising amount of initiative and courage, even following two nuns, who were reluctant to answer questions about Johnny Cash, out into the hall where he managed to get their opinions. The team members were startled at the sudden absence of resistance and were not able to account for it. Later that afternoon Joe's Clinician, capitalizing on this change in attitude, spent the afternoon doing assignments with him. Together they entered, incredible as it seems, 60 different speaking situations in which Joe (1) faked his old sticky blocks, (2) faked some easy audible repetitions, or (3) just monitored whatever difficulty he had. He handled these assignments with assurance and good spirits. By the end of the day his blocks were easy and smooth. He was enjoying it too. The Clinician felt that he had "drained away a lot of the fear."

Despite Joe's increased assertiveness and willingness to take responsibility for therapy, some resistance continued. He began to protest again that he shouldn't have to fake audible repetitions because "they weren't part of my old problem – when they happened they were freak accidents." He also noted that they sent him into real blocks. It seemed clear from these statements that audible repetitions, at least the ones that were audible to Joe, were the cues that precipitated a number of other struggle behaviors. They were the primary noxious stimulus from which he recoiled and against which he fought so hard. From Joe's point of view, the repetitions were not part of his pattern because they occurred only infrequently, but the reason for their infrequency was that anticipating them set off struggle behaviors, and the struggle behaviors were often successful in avoiding the repetitions. Consequently, when they occurred they were "freak accidents." According to this analysis it was all the more important that he be desensitized to this type of dysfluency. It is remarkable how easy it is for a client, in all innocence, to sabotage his own therapy.

On Wednesday, in the first morning session, Joe worked with one of his team members role-playing a number of telephone situa-

tions in which he had reported being dysfluent. At first he was to initiate every word with a syllable repetition. Later, however, he was instructed to talk as normally as he could. The team member applied various forms of conversational stress. The first scene was an employment agency, and the team member treated him badly. Joe handled it pretty well. Then they decided to role-play a scene in which the team member played Joe's father. In the scene, Joe's father gives permission to use the family car and then later retracts it, a tactic which makes Joe furious. According to Joe his father often pulled this trick on him with no purpose other than to make him angry. Joe, realizing that a lot of swearing would take place during the scene, asked that the observing team members, both of whom were female, leave the room. After the remaining (male) team member and Joe composed the details of the scene, they acted it out. The critical point occurred when the father slammed the receiver down and Joe came over to him and they had a face to face confrontation. Joe became extremely involved and emotional during the scene and had a severe block. After a pause, he worked his way through the word by repeating and prolonging the initial phoneme. They concluded the session by going to a simpler task in which Joe performed word repetitions, incorporating the words into sentences.

In the videotaped session that morning Joe's Clinician planned to ring a bell every time Joe's speech was not forward-moving or whenever Joe used one of his old accessory behaviors. Joe's job was to identify what triggered off his blocks and go back and cancel those words on which he used accessory behaviors. After a few attempts, the Clinician abandoned the plan because some of the accessory behaviors seemed to be increasing rather than decreasing. Later in the afternoon, after watching the videotape, the Fellows noted that the punishment had not been administered precisely and that many accessory behaviors went unpunished.

In the next phase of the same session Joe was supposed to identify the trigger postures or the actual site of tension on the lips in some of his feared words. Joe's Clinician administered a local anesthetic to Joe's upper and lower lips. Although it was readministered, it proved ineffective, and Joe mentioned that he often required several shots of novacaine at the dentist and even then his teeth were still sensitive. His Clinician then had Joe repeat several words beginning with plosive sounds. He was supposed to begin with a hard contact and gradually move into the vowel. These attempts were recorded and then played back to Joe. The purpose of this procedure was not fully explained and apparently was not achieved, for it was abandoned almost as soon as it had begun. The session concluded with Joe and his Clinician engaging in easy-going banter,

during which Joe was instructed to monitor his speech.

In the second session that morning Joe worked with the DAF set at no delay but with the same volume level as in the previous sessions. He spoke fluently while reading aloud and again during a monologue, but had difficulty in conversation. He was aware that there was no delay, so the team member had him turn his back to the apparatus. He then had approximately the same number of blocks on no delay as on .06 seconds delay. The rest of the session was spent practicing all three modes of speech while the team member switched back and forth between .06 seconds delay and no delay.

In the afternoon session, Joe first reviewed some of the day's activities with one of the team members while she signaled him with a bell whenever he preceded a word with lip preformations. After a while, they stopped this activity and Joe ventilated some feelings about his family. They then went on to work on some word lists for easy audible repetitions, and Joe compared the difference between prolonging the vowel sound and easy repetitions of the syllable. A number of other techniques were also explored — whispering, repeating in chorus, trying for speed, trying for loudness, and trying for assertiveness while maintaining easy repetitions. As a way of testing some of these techniques, they went to the library where Joe was to fake syllable repetitions while talking to the librarian. He couldn't bring himself to do the repetitions at all and used prolongations instead, afterwards saying that they were not like his real pattern and that they sent him into real blocks.

On Thursday, Joe's DAF program continued in the first morning session. Continuing the work of the past few days, Joe tried to reduce the frequency of stuttering with the device set at no delay, but with a volume level equal to that of the previous sessions. Since his performance level had plateaued at a low frequency, the team member moved him on to the next step of the program, talking with one of the earphones off.

In the videotaped session, the purpose was for Joe to role-play an emotionally stressful situation, and the team member decided to repeat the scene in which Joe and his father argue over the car keys. In order to work up to it, however, one of the team members began by having Joe make up sentences from words or phrases that the team member supplied. This was easy, and Joe prolonged whenever he needed to. The team member and Joe then engaged in an insult-trading exercise called "dirty dozens," in which the purpose is to try and retain composure while insulting, and being insulted by, the opponent. Joe was reluctant to do it. Each time these exercises had been used previously Joe had shown that he did not enjoy cutting

other people down. He tried for a while but then retreated with a silent smile. Abandoning the exercise, the team member began role-playing the scene with Joe's father, beginning over the phone and progressing to a face to face confrontation. There was a considerable amount of tension generated by both participants and, following a heated exchange, the team member tried to analyze what Joe had felt in the past and what he might do in the future if such an argument were to occur. Dr. Sheehan, the Consultant, commented that role-playing situations such as these can fulfill clinicians', as well as clients' needs and that some caution should be exercised in their use.

In the other morning session Joe went out on assignment. Taking a pamphlet on the prevention of stuttering to a medical doctor at the University Health Center was his first assignment. Joe decided to prolong his speech and to "hang a few repetitions on them" – "them" referring to the receptionist, any nurses that might be around, and the doctor himself. He used the repetitions with the receptionist, but when talking to the doctor used only prolongations. Since the doctor turned out to be very amiable, the situation became an easy one for Joe.

That afternoon Joe worked with one of the team members on an outside assignment for which he was to talk to a dealer about buying a mobile home. Joe figured he would probably live in one when he got married, so the situation had some reality for him. He was supposed to have used some easy part-word and whole-word repetitions along with prolongations to pull out of real moments of stuttering. He used prolongations extremely well as releases from stuttering, but he did not use any part-word or whole-word repetitions. He also had two moments of stuttering that he was unable to monitor. Afterwards, Joe and his team member discussed the prolongation technique, and the team member tried to emphasize that it was not just a question of prolonging the sound on which he was stuck, but of moving on, in a prolonged fashion, to the next sound.

The goals for the videotaped session on Friday were for Joe to explain what he is doing with his speech to a new person, preferably an authority figure, and if possible to include a demonstration of his old pattern. As a vehicle, Joe had an interview with Dr. Sheehan. After Joe had demonstrated his old pattern, they discussed the techniques Joe was currently using. Several of the exchanges between them are good illustrations of Joe's attitude. Here is one:

Sheehan: I have a good feeling about you. I think you'll have a long period of sliding through words but eventually you will be very fluent.

Joe: I will. There is no doubt about that.
Sheehan: Do you still cover up?
Joe: No.
Sheehan: Open all the time?
Joe: Yes. Right now I am anyway. I go right through the word instead of changing it.
Sheehan: It's a big relief not to have to pretend.

That afternoon Joe and one of his team members went out on a house to house survey. The idea was for Joe to engage in ongoing speech using exaggerated prolongation. Without any reluctance Joe went through the first two interviews and did a pretty good job of keeping his speech moving. In each interview, however, he began with a starter ("um"), showed some silent lip preformations, and was unable to move forward from the /s/ sound in the words *survey* and *stuttering*. The two team members discussed these observations with him, and he was able to begin subsequent interviews without starters, but was not able to improve on moving forward from the /s/ sound. They also asked Joe to exaggerate prolongations on more words and not use it as a device to help him only during the moment of stuttering, but he was only partially successful. Because he still wanted to be fluent he was using the prolongation as a means of escaping from stuttering. After they finished and were having a coke together, the team member stuttered in front of the waitress as a way of showing Joe that it wasn't so bad. They also discussed again the differences between prolonging the sound and prolonging the transition between the sound and its following vowel. The team member concluded that Joe needed more practice prolonging transitions and that he needed more desensitization to the fear he has of moving smoothly into subsequent sounds. Also needed was practice integrating and initiating air, sound, and movement in pressure situations and increased ability to tolerate the intrusion of audible repetitions in his speech.

In summary, it was, if not a critical week for Joe, at least the beginning of a critical period. In part his vacillation between resisting the voluntary use of audible repetitions and actively seeking out situations in which he could use them stemmed from the different roles played by the team members with whom he was working. One team member had been instructed to play a supportive role with him, and Joe showed his resistance by complaining when he was with her. Being supportive, she agreed with him when he complained. The other team member urged Joe to enter feared situations. He acted as a goad, although he was supportive too. With this team member Joe responded by approaching feared situations. At the end of the third week it was still too early to tell which way Joe was going to go.

There were plans for another weekend in Joe's home town, and perhaps the answer would be found there.

Allen Williams

In the videotaping session on Monday, Allen was asked to talk more, and the team members applied more pressure, particularly the pressure of silence. During the discussion the point was made that Allen would have to learn how to initiate conversations in order for his therapy to be successful. Much of the discussion concerned where Allen felt he was in therapy. He said that he could handle his stuttering through pull-outs and preparatory sets and that he could do it at home or in any situation. He felt, however, that he still had to get rid of *thinking* about his stuttering, and he needed to talk more. He also said that he was still more concerned with his language difficulties than with his stuttering. He continued to anticipate that he would be fluent before the end of the Institute. At one point he had a surprise block, probably as a result of stress induced by his Clinician, and they discussed it at some length. Finally, Allen suggested looking at the tape to see himself as others see him. He was uncertain just how observable his stuttering was to others. Toward the end, the Clinician tried to sharpen Allen's perception of his stuttering behavior by discussing feared words and the other stimuli that precipitate blocks and by explaining some of the distinctions between stuttering and normal nonfluencies.

After watching the videotape, some of the Fellows were concerned that Allen was too fluent and most were concerned about what might happen to him if he found himself unexpectedly in a bad spot. Would he fall apart? Allen's Clinician pointed out that as therapy moved more toward an analysis of sources of anxiety, he thought unexpected bad situations would be less likely to occur.

In the afternoon therapy session, Allen and two of his team members practiced initiating conversations in outside situations, particularly stressful ones. They went to the laundromat together, and Allen began a number of conversations with some of the other people there. In each case, however, Allen took a bantering or humorously antagonistic tone. For example, he approached a lady whose little boy had a black eye and said "Where did he get the black eye? Did you pop him?" Most of the time, the other person laughed, and the laughter seemed to reduce the stress of the situation. Allen, at any rate, reported afterwards that the situations had not been stressful. Nevertheless, he had blocked several times, and he had not been able to control the blocks. But, by the end of the afternoon, he had initiated 94 conversations.

In Tuesday's videotaped session, Allen and his team talked with each other for a while and then stopped in order to play back the tape and take a close look at Allen's stuttering behavior. The conversation was about Allen's public address class, and Allen said that many of the class members didn't think he stuttered. While he was talking his hand movements seemed unusual, and the Clinician asked whether he was using them as a distraction or pacing device. "I don't think so," Allen said, "well, maybe to a very slight degree." The Clinician suggested that Allen spend some time trying to sort out his normal gestures from those that were related to his stuttering.

At this point, the tape was stopped and played back. The Clinician asked about a rapid, relaxed repetition which had occurred several times on the word *I*. After a brief discussion, Allen said, "I guess I better work on the spooky part of the word *I*. Several other behaviors – an eyeblink and a slight lip movement – also prompted brief discussions. While demonstrating how he coped with one of these behaviors, Allen discovered that, although the tension was located at the laryngeal level, he had been trying to modify it by easing off tension in the articulators. Under instruction from the Clinician, he practiced reducing tension in the larynx.

In the first afternoon session, the goals were to analyze Allen's facial movements and draw up a therapy plan for reducing them while working at the same time on repetitions and silent pauses. Allen and two team members talked first about slight lip movements that he showed during silences. After a discussion, Allen determined that they were the highly habitualized result of former repetitions, originally prompted by fear, that had been inhibited, but they were also related to language formulation: "I've been thinking about what I'm going to say and I say a word but don't have the rest of the phrase formulated, so I pause and get lip movements which used to be repetitions." Part of the problem, apparently, was that Allen was pausing at inappropriate times, such as in the middle of a word, to formulate the rest of an utterance. A plan for dealing therapeutically with these behaviors was then devised, including a reduction of the fear that preceded them, voluntary practice to "get the feel" (increase awareness) of them, and modification of the pattern of pausing behavior.

In the second afternoon session, Allen said he wanted to concentrate on modifying his pausing behavior. This prompted a discussion of the difference between the way Allen pauses during speech and the way nonstutterers pause, particularly with regard to the timing of the pause. As a vehicle for modifying his pause behavior, Allen started to deliver the speech he was to give the following Friday, but he only spoke for a minute before blocking. After a brief

discussion. Allen tried again to deliver his speech but again he blocked. This time Allen and the Clinician analyzed closely what had happened in the second block. The primary problem was expectancy due to past trouble with the word, especially the first letter or syllable, and a number of therapies aimed at desensitizing Allen to the feared sounds were suggested. At the end of the session, the Clinician voiced his concern that Allen wasn't desensitizing himself to dysfluency as much as the Clinician would like and suggested that Allen seek out some situations in which he could fake some stuttering and report back on his reactions.

In the first morning session on Wednesday, Allen and his team discussed outside assignments. Nine situations were presented to Allen, who ranked them in order of stressfulness. From the list, he picked an assignment in which he would interview the manager of the student bookstore and ask questions about its operation. With a team member, Allen left to carry out this assignment. Unfortunately, the manager talked incessantly, and Allen didn't have a chance to get much in. On the few occasions when he did speak, his speech included a number of short, rapid repetitions, which Allen said later were partly voluntary and partly involuntary. He then interviewed a male student about the bookstore and again had frequent rapid repetitions. The team member asked him why he was so dysfluent, and he said that he had been "thinking about the situations we were going into" and it made him dysfluent. He then interviewed another male student and again had a number of repetitions, which he said were involuntary and occurred because his frame of mind put him in a "stuttering mood." He then interviewed a girl and was perfectly fluent, which he said was normal for him. After the situations were completed, the team members and Allen discussed the way in which the stress of communicative situations can vary.

In the videotaped session that morning, Allen and his Clinician analyzed the short syllable repetitions in an attempt to find out what caused them to occur. As a vehicle for discussion, Allen related past experiences which, it was hoped, would also reveal some insight into what precipitates the repetitions. He talked about a number of childhood stuttering experiences, but it didn't seem to be furthering his understanding of the repetitions. Consequently, the Clinician changed the subject and took the rest of the session to explain the process (and value) of making smooth transitions from phoneme to phoneme.

That afternoon, Allen went on a number of assignments with two members of his team. He decided that his first assignment would be the same one Joe had used trying to talk the people at the Housing Bureau into letting him have off campus housing despite the

fact that he wasn't even really a student at the University. He planned on stuttering severely. At the Housing Bureau, he had long and severe blocks, accompanied by facial mannerisms. Afterwards, he said that the stuttering had felt real, but it never actually *became* real.

As a second assignment, Allen decided to tell a local bank officer that he was thinking of going into business and solicit some information about opportunities in Marquette. To raise his anxiety level, he decided to allow himself to have a repetition and then get out of it, signalling the team member as he did so. Unfortunately, the bank officer knew the team member and sensed that the situation was some kind of an assignment. Furthermore, Allen's short repetitions gradually faded into fluency. The third assignment was to ask for a three per cent discount while trying to make a purchase in a local store, and, if it wasn't given, to refuse to buy the item and ask to see the manager. (The rationale for requesting the discount was that holders of certain types of "universal" credit cards actually pay less for an item because the store owner pays the bank three per cent of the purchase price for the service without charging the customer more. Allen, who was paying cash, had, in a sense, to pay three per cent more because he was not using a credit card.) While talking to the clerk, Allen had some voluntary short repetitions and pulled out of them, but he was dysfluent for three to four words after the concealed tape recorder unexpectedly squealed. He then asked to talk to the store manager and had a heated, but theoretical, discussion with him. He did not carry out the assignment he had set for himself, but his frequency of dysfluencies was probably within normal limits.

On his fourth assignment, Allen talked to the Food Service Department of the University about setting up a banquet for the Institute participants. Although such a banquet was being discussed, no one seriously considered having the University Food Service supply it. He planned on raising his anxiety level in some way and then using pull-outs and preparatory sets. As he carried out this assignment, his anxiety level was obviously high. In the initial conversations with the secretaries, he was having two to three dysfluencies per sentence, but he pulled out of them about 75 per cent of the time. While talking with the Food Service Director, Allen said later, his anxiety level was extremely high. The team member observed that Allen used smooth preparatory sets whenever he sensed approaching dysfluency, but this tactic was not always successful.

His fifth assignment was to interview five students about the University Bookstore. On this assignment, he decided he was going to talk fluently. He had a few short repetitions with the first student,

was fluent with the second and third students, and had severe laryngeal and oral blocks with the fourth student. With the fifth student he had accessory facial movements during his dysfluencies and a number of short repetitions on which he used preparatory sets. Discussion of these assignments was postponed until the following day.

On Thursday Allen and his team continued to analyze his short repetitions. In Allen's opinion, these dysfluencies began with a normal nonfluency which set off a chain reaction of facial behaviors and repetitions. There were three situations in which the repetitions were likely to occur: (1) trying to increase his rate of speaking, (2) trying to communicate in a competitive situation, and (3) trying to increase his rate of formulation. Several strategies were discussed for dealing with these situations, such as using a filled pause ("ah") in order to hold the floor while he formulates. Showing some resistance to therapy for the first time, Allen asked his Clinician why he didn't just tell him what he had observed instead of trying to guide him to find out for himself. By finding out for himself, the Clinician reminded Allen, he develops more skills for working on his problem. Furthermore, the Clinician's observations have less chance of being right than Allen's when Allen is the one being observed. Returning to a consideration of Allen's repetitions, the Clinician suggested that therapy take the form of desensitizing Allen to the repetitions. Allen requested more information, and the Clinician proceeded to give him a detailed description of fear conditioning and its relationship to the syllable repetitions. Another therapy, counterconditioning, was also suggested instead of desensitization. Allen decided that his therapy for that day would be deconditioning.

Allen then began to practice with his team, reading aloud and repeating on every syllable. It was difficult for him at first, and his Clinician explained that he should speed up the rate of repetitions gradually, then slow them down, before going on to the rest of the word. Eventually, Allen decided he would stick with slow, audible repetitions. He had to be cautioned at one point against letting a pattern (three syllable repetitions on every word) develop, but he continued to practice, occasionally using extremely long (2-3 minutes) repetitions. It seemed to one of the team members that Allen had difficulty performing this task without tension. Toward the end of the session, however, he began to recognize the distinction between faked stuttering, which included tension, and voluntary repetitions, which did not.

The same therapy continued during the videotaped session that morning with Allen intentionally producing syllable repetitions in the absence of negative emotion at a rate and in a manner that would not precipitate a tremor. As a vehicle for this practice, Allen interviewed Dr. Sheehan. The plan was for Allen to produce syllable

repetitions, do most of the talking, and create some interpersonal tensions. Allen began the interview by using a very long repetition and continued to use repetitions for the first four or five interchanges of the interview. After the first few minutes, however, Allen began to take a somewhat belligerent tone, consistent with his third goal, and the interview gradually degenerated into a verbal power struggle. For example:

Sheehan: What are your goals? Other than keeping me from dominating? Do you have trouble talking to authority figures?

Allen: Why did you wear a suit and tie today?

Sheehan: I like it. Its my working uniform. *(pulling papers, a lighter, etc., out of his pockets, to demonstrate one of the reasons why he wears a suit coat but in the process dropping a paper on the floor).*

Allen: Were you getting nervous?

After a few more interchanges of this type, Allen began to use fewer and fewer syllable repetitions. At one point the conversation began to turn toward a more normal tone, and Allen had a series of short, real blocks, which he did not handle. Allen then went back to trying to dominate and frustrate Dr. Sheehan. The session ended with both Allen and Dr. Sheehan expressing the desire, somewhat cautiously it seemed, to talk again.

That afternoon, when the Fellows viewed this extraordinary videotape, Dr. Sheehan was present. He commented that syllable repetitions may be used as aggressive behavior by stutterers, as Allen had apparently done. He noted also the intelligence it required on Allen's part in order to manipulate the interview situation so successfully. The question of whether Allen's language formulation difficulty was an avoidance behavior, a "cop out," was raised again, and Dr. Sheehan tended to agree that it was just that. Certainly, Allen, from observations of his hand and arm movements during the interview, did not appear to be as relaxed as he claimed.

That afternoon, Allen decided to enter a number of situations in which he could desensitize himself to his simple, nonstruggling repetitions. He was to mass these easy repetitions while maintaining a mental set of positive emotion. During the afternoon he used repetitions on at least 50 per cent of all the words he spoke. Although he occasionally had small, real tremors, he was almost always successful at maintaining easy, tension-free repetitions. He, and the team member went from door to door to survey townspeople on their reactions to stuttering, Allen either writing questions beforehand or ad-libbing them during the interviews. They talked to a teen-age girl, two workmen, a young girl, two young boys, and an older woman. Some of the situations were difficult for Allen and some were not, but

throughout a total of about twenty situations, he used slow repetitions. Afterwards, he said that it had been a successful afternoon.

On Friday, in the morning session, Allen's Clinician counseled him that some therapy had to be directed at reducing the need to be fluent. The Clinician pointed out that there were two basic types of therapy for this, one that dealt directly with the blocks and involved pull-outs and preparatory sets, and another that dealt with the sources of tension and involved desensitization to, and increased tolerance for, dysfluencies of all kinds. Allen felt that he should go out on more assignments. He then left with a team member and went to a number of stores downtown with the intention of pursuing the same goal he had the preceding day – using slow easy repetitions on at least 50 per cent of the words spoken while maintaining a positive mental set in order to desensitize himself to his own repetitions.

At a candy store, the sales clerk interrupted him and finished his sentence several times. Allen persisted in his repetitions but was not relaxed. At a jewelry store, his repetitions were noticeably more relaxed and he continued the conversation at length. He then went into four more stores, where he experienced definite success. That afternoon, Dr. Sheehan reported on a conversation he had with Allen earlier. It had been a relaxed easy chat, "outside the arena of the TV camera," and he felt first that Allen was not as language-disabled as he thought, and second, that he had a good fluency capacity and a good prognosis.

Later that afternoon, Allen entered a number of situations with the goals of maintaining fluent speech and having the team member observe his short syllable repetitions to judge if they were the stimulus for more dysfluencies. They went downtown where Allen interviewed some bartenders to get their observations on the behavior and social problems of people who drink. This information was to be used for his public address the following week. After some initial difficulty in approaching potential interviewees, Allen gradually grew more relaxed. There were a few syllable repetitions, but they did not increase in number nor did they seem to trigger more anxiety. Later in the afternoon, Allen asked about the pronunciation of a word. After saying it a few times, he said "It's like learning a new language." He said that during the past few weeks of therapy he had asked for the pronunciation of many words that he had heard many times but never tried to say because he was afraid he would stutter on them.

In the other morning session, Allen and his team discussed further assignments for the continued purpose of trying to discover if small real repetitions would precipitate other behaviors.

By the end of the third week, Allen's therapy program had acquired some direction and focus. Of course, since he was directly responsible for relating his therapy program to himself and his own needs, therapy may have been more focused for him than it seemed to someone else. Certainly, his speech was improving.

Robert Roth

During the weekend between the second and third weeks, Bob went fishing with one of his team members. She noted that he was working consistently on his speech during this time, and it was the best she had ever seen. The rate was slower, the articulation clearer; and he was "moving through the words" almost all the time. Of a number of minor blocks, he cancelled all but two, although he frequently got a word or two past them before going back and cancelling. If he didn't move through a word to his satisfaction, he repeated it. He once asked the team member to remind him if he speeded up. The same team member saw Bob a few other times during the weekend. She felt that when he was not working on his speech he had difficulty coping with his free time. He seemed to need help finding activities that interested him, although he also rejected reasonable suggestions for things to do.

In the first therapy session Monday morning, Bob was to discuss what he had learned about himself, his feelings, and his stuttering over the weekend. While talking, he was to (1) maintain a constant monitoring of movement while speaking and (2) stop and analyze his lapses from monitoring, whether they were natural fluency or blocks. For the most part, he did an excellent job of monitoring, lapsing into fluency or stuttering five or six times. When he did fail to monitor, it was, he thought, fear of interruption that diverted his attention from monitoring. The team member who spent this session with him suspected that he may have been writing off most lapses to fear of interruption because he wasn't sophisticated enough in this kind of analysis to identify anything else yet.

In the first session Monday morning, one of Bob's team members explained the use of cancellations to him. She also explained the use of negative practice, proprioceptive monitoring, and the identification of communicative threats. The team member noted at this time that Bob may have been modeling his articulation after that of his Clinician.

In the planning session, Bob's team and his Clinician decided that during the videotaping that morning they would start teaching him to use preparatory sets and negative practice. His assignment would be to scan ahead, stop before he would stutter, mentally go

over how he would start the word correctly, then "project this mental image into the approach," and say the word with proprioceptive movement and awareness. He was also supposed to put more energy into the shift from rapid to slow tremors. When he failed to monitor his speech proprioceptively he was to make a note in writing of the circumstances. And if his cancellation was not good he was to go back and cancel again.

On tape, Bob talked about situations that he found difficult to cope with, referring to a prepared list of situations his Clinician had given him. His thoughts seemed superficial, as if he had taken them right out of a textbook. He was, however, adept at scanning ahead for situations where he might fail. If his pull-outs were not effective he was generally able and willing to go back and cancel the block. Because he was concentrating on scanning, or possibly because he was using his Clinician as a model, his articulatory contacts were loose, giving his speech a slurred quality. This suggested the need for more energy and a stronger movement through the sounds.

After the videotaping, the second morning session began with a discussion of the afternoon activities. For the afternoon, assignments were designed to identify communicative stresses, to determine how Bob copes with these stresses, and to identify alternative procedures. Bob suggested that he be placed under stress by having the team members interrupt him and fill in words for him. Although they did this it did not affect the stressfulness of the situation, according to Bob.

That afternoon, Bob spent two hours downtown looking for speech situations with one of his team members. The purpose was to identify stresses that he might encounter. At a gas station, Bob was to initiate the conversation in order to ask directions but then wait five seconds before beginning his utterance, using two or three "uh's" instead of silence. The young male attendant waited after his first puzzled look and then was so dysfluent when he replied that it made Bob feel like the fluent speaker. At another gas station, Bob faked moderately severe stuttering on several words and was interrupted, but he kept talking. At a drug store, Bob again tried silence before beginning to talk but didn't seem to learn much from the encounter. He then faked stuttering to a middle-aged female clerk. Although she was clearly embarrassed, she did not interrupt. In the same drug store, Bob had a longer encounter with a customer. It began when Bob asked him for a particular magazine Bob wanted. Bob recognized this as a stressful situation because it made him feel helpless, and, with the team member, he analyzed ways to handle the situation. Bob went on to find seven or eight additional situations in which he felt stress. He maintained monitoring well, although there

were some failures of both varieties – fluency and real blocks. But he continued to work hard, even suggesting several hard assignments for himself. The team member with him thought the most significant results were his reactions to over-helpfulness, his panic at real blocks, his ability to control them, even though primitive, and his willingness to verbalize his feelings about the situation. Part of the difficulty, to be expected in a seventeen-year-old stutterer, was that his social skills in relating to girls were not yet very polished. Many of the situations that were difficult for him had involved young attractive females.

In the first session Tuesday morning, Bob reviewed these activities from the preceding afternoon and felt he had learned a number of things. He realized that few people look at stuttering as something strange to laugh about, since only one person had done so and another had been very dysfluent. He also learned that there is an easy way to stutter, for when he got into a real block he was able to ease his way out of it. Perhaps most important, he felt that his speech could be helped, for he found that he was able to monitor himself.

Despite these positive reactions to his assignments, Bob felt that he needed to practice in more stressful situations so that he would be able to handle his blocks when he went home. For his assignments later that afternoon he wanted to (1) resist talking too fast and (2) see if he could get his listeners to say "what?" He then listed a number of communicative threats: time pressure, talking to girls, speaking in a class, having a clerk ask him a question, and trying to speak fluently. Of course, the last of these may have been a summary of all the others.

In the videotaped session that morning Bob discussed further his assignments of the preceding day while proprioceptively monitoring every word. A fundamental goal of this session was to get Bob to take primary responsibility for all aspects of his therapy. In the first part of the tape he recapitulated the therapy session he had had earlier that morning. Then, a team member asked Bob what procedures he thought he might want to use in order to learn how to resist pressure. He suggested speaking to people a great deal for practice in resisting pressure, particularly the pressure to speak the instant the urge to do so arises. Just resisting the urge to speak, he thought, would increase the pressure to speak. This was the first time Bob had voiced any insight into the compulsive quality of his speech, a characteristic which the Fellows thought was related to his stuttering. It was hoped that he would have more insight of the same kind and that the nature of the relationship between his compulsion to talk and his stuttering would be clarified.

During another morning session, Bob watched a videotape that

he had made during his evaluation in Kalamazoo. He had had many very severe blocks at that time, and the goal was for Bob to develop a resistance to these blocks by talking with himself fluently as he stuttered on the tape. He showed some anxiety before the tape was shown, asking that the videotape technician leave the room. The technician stayed, however, and Bob went ahead with the assignment. First, when stuttering occurred on the tape, he repeated the sentence (live) fluently and strongly. Then he waited after saying each word until the stuttering moment on tape had passed before going on to the next word. He made a number of humorous, self-derogatory comments, such as "I can't understand that stupid kid." Watching repeatedly a particularly severe stuttering moment, he analyzed the original and repeated the word several times to himself. He also practiced duplicating the beginning of stuttering, pulling out, and cancelling, in response to several of the stuttering moments on tape. At the end of the tape, he said to the team member "Now you've seen the real me." When the team member questioned the statement, Bob said "Well, that was the way I used to be." At lunch, he was quiet, didn't kid around as much as usual, and appeared upset. His speech, however, was fluent.

In the first afternoon session, Bob went on a number of assignments with the purpose of developing resistance to communicative stress or threats. Having selected, along with the team members, a series of situations that were more stressful than those of the preceding day, Bob was reluctant, almost resistant, to participate, and he showed less spontaneity and imagination than usual. He entered several situations, however, and dealt with them in various ways. In a store, he paused for five seconds before initiating an utterance and successfully resisted the pressure to shorten the pause. At a bank, his goal was to observe a listener during a block, so he faked a block to a young teller, but did not see her reaction because he had looked away during the block. In the police station, Bob planned to monitor his speech, simulate his old pattern in a severe block, and look at the listener. This time he maintained eye contact, and saw that the policeman looked away when he blocked. They were interrupted during this conversation, which added some stress, but Bob continued to monitor his speech. Bob's mood seemed to improve for the rest of the afternoon. He didn't complain any more, and he showed more initiative. At an ice cream stand he decided to mumble his first few words so that the girl would have to ask "what?" and then simulate stuttering if no genuine blocks occurred. Since he felt no stress in this situation he initiated his old type of block on two words, looking at the girl throughout, and correctly reported no overt reaction on her part. At a gas station Bob said he

wanted to try one thing that he hadn't done yet – to talk normally, that is, without monitoring, to see if genuine blocks occurred, and, if so, whether or not he could pull out of them. He did this, and had only one brief block, which he did not pull out of.

In a later afternoon session, Bob worked under DAF with delay times varying from .18 to .22 seconds. Bob fell into a sing-song pattern until he was reminded about it, and he found it more difficult to monitor his speech proprioceptively than on previous days. He needed to be reminded frequently.

On Wednesday Bob's first morning session was designed to help him analyze his reactions to success and failure in the stress situations he had encountered the day before. After he had said several times that he felt positive about the experiences he had had, the team member wanted to know if Bob was giving answers that the team member wanted to hear – saying what would please him. Bob considered the idea, but the question was not resolved. They returned to a discussion of his assignments, and he said "When you fake and people laugh it doesn't really matter, because you were faking anyway." Then after a brief silence, he asked "So why should it matter when I'm *not* faking?" He toyed with the idea for a while and thought it was a good one, and his team member agreed. They then turned to an analysis of situational cues. After a brief discussion, Bob suddenly realized what the term "situational cues" meant and he rather excitedly dictated the following: (1) people laugh, (2) he *thinks* people laugh, (3) someone says "what?" (4) a person looks questioning (raised eyebrows for example), (5) a person asks "how can I help you?" (6) people try to guess what he is going to say, (7) friends try to guess what he has said, and (8) friends fill in words he is trying to say. The team member asked him what he could do to resist these pressures, and he said he ought to stutter more; "It would make me desensitized." There was some question as to whether he really understood what *desensitized* meant, but the team member suggested that he try it and see how it felt. This was obviously a very important session in which substantial gains were made in several areas.

In the planning session that morning, Bob's Clinician suggested that Bob identify some of the situations that would be stressful for him when he went home. Because Bob had shown signs of being satiated with assignments around town, the team felt he needed to get into situations he personally cared about and in which he would be emotionally involved.

In the videotaped session, Bob's Clinician asked him to talk about the difficulties he expected to encounter at home. Bob said that the first challenge would come when he got off the plane, and

the challenge would be to see if he could speak fluently. As the discussion continued, the group talked about strategies Bob could use to handle blocks and to cope with the general situation of returning home. Gradually, the topic gave way to a discussion of Bob's social relationships. Throughout this session Bob's need for fluency seemed strong, and it was from this motivation that he explored strategies for handling blocks.

In the second morning session Bob again watched the videotape he had made in Kalamazoo. This time, his job was to pick out how he initiated the blocks and what he did when expecting to stutter. The procedure was to examine the way he had stuttered on individual words. Bob spoke with good understanding about articulatory events but did not mention his feelings. With some prodding, however, he began to relate his stuttering to emotions, as well as to articulatory events. Usually, however, when asked a question about his emotions, he would mention hostility, saying either that he stuttered because he felt hostile or that he felt hostile and vented his hostility by stuttering. There was a quality of superficiality to this response. It came too quickly and too easily. Futhermore, other aspects of Bob's behavior suggested that he was anything but hostile toward those around him; he craved approval and affection. In his serious interactions with others, he was quiet, softspoken, and sensitive. The only behavior he had that seemed at all related to hostility was bantering. Bob's stuttering was more probably related to his need for approval than to hostility, and his frequent references to hostility were either what he thought the team wanted to hear or a way of protecting himself from the possibility of rejection. If this analysis were correct, Bob seemed a long way from understanding the dynamics of his stuttering.

After watching the videotape that afternoon the Fellows mentioned the fact that Bob's Clinician had shifted to describing Bob's stuttering as something Bob was doing, thus placing the responsibility for speech on Bob's shoulders. The Fellows also suggested that Bob's projected difficulties returning home could be solved with systematic desensitization or role-playing.

That afternoon Bob went out on assignments in town. He had complained that the assignments were no longer challenging, so his team member suggested that he propose the assignments himself. They planned the assignments in detail, determining in advance the exact wording of the sentences and the occurrence of specific types of stuttering on particular words. Each of the tasks was then carried out with good success.

In the morning review session the next day several Fellows commented that Bob's behavior seemed to have changed dramat-

ically – he acted more mature and more open in his interactions with the Fellows. During the days that followed this comment was made again and again, so it was not a temporary or insignificant change in Bob's behavior. What had happened? For one thing, the brash, bantering patter was gone. A few days earlier, Bob had two primary styles of communication – one was a humorous "put-down" of the other communicator, delivered as a series of "one-liners" which allowed little opportunity to respond. The other was the communicative posture of a child, which included a whining tone of voice, coaxing, wheedling, and other, more subtle ways of manipulating the other communicator. Within the past day or two, these two styles of communication had given way to a straightforward, content-oriented style. But what did it mean? Bob's personality hadn't changed overnight, although his behavior had. The best explanation seemed to be that Bob had somehow come to trust the Fellows. He was willing to communicate with them more openly, trusting that he would not be rejected. His old styles were defensive, a series of devices to protect him from this rejection. In his view, he hadn't given us the *opportunity* to like him, so we had never been able to decide that we didn't. But things had changed.

It was difficult to determine, however, what had precipitated the change. It seemed likely that the first therapy session the day before had something to do with it. It was in this session that Bob's team member had asked him if he was answering questions about his feelings honestly or just the way he thought the team member wanted to hear them. Although he denied any lack of honesty at the time, he could hardly have done otherwise, and it may be that this gave him food for thought. In the next few sessions he described his feelings either inconsistently or with reluctance. A few other changes in Bob's behavior, apparently reflecting a more responsible attitude were mentioned: he had approached a very difficult situation – talking to young girls – and had faked some hard blocks. He had also had a real block which he pulled out of. He still sought hungrily for acceptance, however, and, perhaps driven by that hunger had mentioned to a team member that he was considering speech pathology as a profession. The suggestion was made that the team should exploit this interest for therapeutic purposes.

In the first session Thursday morning, Bob discussed what he had learned on assignments the day before. He expressed highly positive feelings about them, but the conversation quickly turned to the need for frankness in discussion. Bob seemed to avoid this topic, and they went back to discussing the assignments. Toward the end of the session Bob again voiced concern with the difficulty he was going to encounter when he went home.

In the next session the topic of re-entry was pursued in an attempt to help Bob discover what things he would need to do to make the re-entry as smooth as possible.

Bob then spent another session viewing his old videotape, the one made in Kalamazoo, in order to recapture his old stuttering pattern and learn how to resist it. Bob did a good job of analyzing his old blocks and was able to imitate them well.

During the videotaped session, Bob interviewed Dr. Sheehan. The interview itself was not really an assignment, but some of Bob's statements are suggestive of his attitude. When asked why he wanted to work on his speech, he said "It is too much struggle." He said that fluency is his goal but that it is very hard to achieve, and he is working for fluent stuttering right now. And when he was asked if stuttering was something that happened to him or something that he was doing, he said "I know it is something I do, but it feels like it just happens." In the later part of the session, a few surprising interchanges took place. Dr. Sheehan said, as part of a larger statement, that "stuttering is what you do to keep from stuttering," to which Bob replied "that is just a theory; I want facts." He was actually challenging Dr. Sheehan. When Allen had challenged Dr. Sheehan, no one was too surprised; Allen did that sort of thing all the time, but for someone who craved the approval of those he came in contact with this was startlingly different behavior. Dr. Sheehan began to talk about covering up and playing a false role, and Bob actually interrupted him and said that there was no evidence, and he continued to press Dr. Sheehan argumentatively. Bob's comments may have been superficial, something he had heard or overheard, but his assertiveness was something that had not been seen before. Of course, he had heard about Allen's interview with Dr. Sheehan, and this may have served as a model for him, but he looked pleased with himself afterwards. The interview was successful in other ways; there was a genuine exchange of ideas in a fairly normal communicative situation. Bob's ideas were not always logical or clear, and he may have said what was expected at times, but on the whole he held his own quite well. His speech was well inflected and his articulation was excellent. Intermittently, he used easy prolongation, cancellation, and some faking. He may have had one real block, although he insisted afterwards that it was also faked. Dr. Sheehan commented after the taping that Bob didn't seem to have much need to continue stuttering. He thought that the possibility of direct therapy was by no means exhausted and recommended that Bob see the tapes himself.

That afternoon Bob went on outside assignments with one of his team members. He faked some blocks while ordering lunch and

then asked the waiter how he had felt when he heard the stuttering. When the waiter said he had talked to many stutterers and had no reaction, it confirmed Bob's growing idea that stuttering may not be as disturbing to others as he had thought. Faking one block and pulling out of a real one while talking to a teen-age girl, he found that she did not react visibly to his stuttering. He then approached an attractive college girl and tried to monitor his speech, but without much success – he had two real blocks which he canceled. After watching a waitress react to one of his team members faking a block, he interviewed her and found that she too had not been particularly disturbed.

In the later afternoon session Bob spoke under DAF in order to maintain proprioceptive monitoring and to emphasize the first sound in words. A .2 seconds delay time and a gain of 10 were used for the entire period. Bob spoke for 15 minutes, and the session was recorded on tape and played back for him immediately afterwards. During the playback he was able to identify words and phrases on which his monitoring was not adequate. The team member and Bob then talked for a while about other matters, while Bob monitored his speech. He did this successfully most of the time, athough he did not emphasize the first sound as much as he should have. At the end of the session Bob said that he didn't want to monitor utterances composed of single words or short sentences, only longer ones. He also said that it was more difficult for him to maintain monitoring when he was discussing something of interest to him or when he had something to say, than when the topic was inconsequential.

On Friday morning Bob was supposed to videotape a session in which he would recount to one of his team members how to perform a task. The topic Bob chose was how to skin a rabbit. The team member's role was to listen and ask questions about the content. Specifically, Bob was to resist any fear he might feel that the listener knew more about the subject than he did (a previously stated fear), to resist looking at the camera, and to monitor his speech throughout. If he blocked, he was supposed to work through it. He was also supposed to resist time pressure and the temptation to shorten the description in order to seduce the listener into talking. Although the assignment was carried out smoothly, there was little possibility that the team member knew more about the topic than the speaker, so that one of the pressures Bob was supposed to have resisted was not present. He was fluent during the half hour except for three small blocks. His speech sounded quite natural, and the Fellows, viewing the videotaping later that afternoon, commented that they were unable to tell whether he was fluent or whether he was monitoring.

In the DAF session that afternoon Bob told the team member that he was tired, but he wanted to work on the DAF anyway. As they worked, he seemed fidgety and disinterested. He was not monitoring very much, but the DAF was not affecting him much either. As the session went on he became increasingly bored and depressed, until the team member stopped and asked him if he was getting anything out of the session. He said that he wasn't, that he didn't understand the purpose of working with DAF and didn't know what he was supposed to do. The team member then counseled him on the need for occasionally resting and that it was not a good idea just to give lip service to a therapy session when he was too tired to be effective. Further explanation of the goals and procedures of DAF therapy were also explained to him.

That afternoon Bob went on an assignment outside the clinic to see (1) if he could maintain proprioceptive monitoring during communicative stress and (2) to fake stuttering for the purpose of evaluating the listener's reaction. He did this in eight different situations and was able to monitor his speech most of the time. Occasionally, under stress, he forgot to monitor and did have some real blocks, but he cancelled most of them. Most of the situations involved talking to girls on the beach, and this seemed to be a genuinely positive experience for Bob, if only because he found out he was able to initiate conversations with girls and not suffer any dire consequences. Also a few times he was summarily rejected and took it in good spirit.

Bob's third week was clearly an important turning point in his relationship with the Fellows, but this sudden and dramatic change in behavior seemed curiously unrelated, at the time, to his progress in therapy. He continued to work hard, occasionally too hard, and made progress in understanding his stuttering and in dealing with it. Perhaps in the fourth week the effect on his therapy of his change in communicative style would become visible.

Group Activities

On Monday the group therapy session was videotaped. It turned out that none of the clients knew much about the therapy programs of the others. They just didn't talk about it when they were in the trailer or outside the clinic. Each of the clients then mentioned what kind of work he was doing, and the Clinician suggested that they experiment with these plans overnight. He cautioned them to distinguish between helping each other and bugging each other. Joe reported that he wanted a little bit of help but would get very tired of it if they continued with too much tenacity, and Allen replied "Let's try it for tonight and see how it works."

On Tuesday Joe was out on assignment, so that only Bob and Allen met for the group session. Some of their discussion centered around Joe and the fact that he did not talk very much in the evenings and also that when he did talk in the trailer he was fluent most of the time. A number of suggestions were made about how they might get him to talk more. Allen and Bob discussed how many blocks they had caught each other in and how many of them were faked. Some of this catching occurred during the session itself, and both clients thought it was helpful. The leader for that week, Allen's Clinician, suggested that they consider the kind of help they might get when they went home. Bob said he would get no help. Allen said he would get understanding from his father, but that eventually it would end up in an argument. Bob said that he would not ask for help and that he would get more stress, but he thought he could handle it.

On Wednesday, the clients told their leader that they did not need him that day, so he withdrew from the group, although he remained in the room. To Allen he gave the goals that he had established for the day's session, which were (1) impersonating one another in order to get "the feel" and (2) stimulating each other to talk more and help each other work in the trailer. Allen began by impersonating Bob, and Joe realized it. Each in turn imitated the other, and the success of the imitations was then evaluated by the group. A discussion followed in which they analyzed each other's behavior in some detail. The leader suggested that Bob and Joe switch their stuttering patterns for a while and carry on a conversation. They did this for a few minutes, and then the leader suggested that they switch not only speech patterns but content as well. They had been talking about their home towns, Bob defending city life and Joe's country life. Bob, who had earlier been vociferous in his praise of New York, found himself in the position of attacking it. He did so with great vigor, convincing himself in the process, and appeared to gain some real sensitivity to Joe's feelings.

On Thursday, the leader reviewed the group's activities of the past week. He suggested that the session be spent exploring any problems each may be having in coping with his own stuttering behavior. Joe said he was having difficulty using repetitions, and Allen was reminded by his Clinician that he was having the same problem. When asked how he was handling it, he said that he had been trying to produce the repetitions too rapidly and had found that slowing them down made his efforts successful. Bob said his greatest problem was his fear of returning home. The leader suggested that they consider how different the problem of stuttering becomes if they do not try to hide it. All agreed that bringing it out

in the open was helpful.

On Friday, Allen's Clinician decided to have the group work toward doing therapy with each other – a team approach among the clients – by taking over their group therapy during the final week. Joe suggested outside assignments, which Bob confirmed. Finally, on Allen's suggestion, they decided to do their planning in secret, and the Clinician and observers left the room. The schedule was then given to one of the observers at the end of the session, and it was as follows:

Monday

Four situations: Bob stuttering in the library, Joe stuttering in the cafeteria, Allen stuttering in the dorm, and all three of them stuttering in the bookstore.

Tuesday

The clients will teach the Clinicians the correct way to stutter the way they do.

Wednesday

A videotaped session – the clients will try to talk fluently, using as much therapy as possible. They will also discuss how the individual methods of therapy have helped the individual clients.

Thursday

Joe's Clinician and the clients will go downtown and stutter as dysfluently as possible.

No plans were made for Friday.

At the end of the third week, the group had not only used the group therapy time to achieve some understanding of each other, they had mutinied. The next week would tell whether they would continue learning from each other.

THE FOURTH WEEK

Joe Du Pre

Over the weekend between the third and fourth weeks, Joe, his Clinician, the Clinician's wife, and one team member met in Joe's home town, where Joe introduced them to his girl friend Ginny. Joe had already carried out a number of assignments involving voluntary, audible, part-word repetitions, so the Clinician, as a change of pace, sent Joe and the team member to a local store where the team member inserted "um" repeatedly while talking to a clerk and Joe observed her reaction. After discussing it briefly, they went into another store, where Joe used a lot of "um's" himself, and, when the clerk tried to help him by filling in words, he let her go right on guessing while he went on 'umming." Throughout the day, Joe carried out his assignments willingly and with success. When not performing on assignment, he moved through his blocks with prolongations.

Part of the day's activities were designed to change some of Ginny's attitudes. Ever since she had known Joe, Ginny had helped him avoid speaking situations, frequently speaking for him. It seemed likely that, by doing so, she was fulfilling some of her own needs as well as Joe's. If so, she would have to give up this source of reinforcement if Joe was to learn to stop avoiding difficult situations. Since there was a possibility that Ginny, in all innocence, might try to sabotage Joe's therapy, something had to be done to make sure it wouldn't happen. With this end in mind, Joe's Clinician and his wife talked to her while Joe and the team member were on assignments, counseling her in the part a stutterer's wife or girl friend could play in his rehabilitation and explaining to her how important it was for Joe to stop trying to hide his stuttering.

When Joe had finished his assignments, the group reunited, and Joe took them out to his family's summer home in order to have them meet his father. As planned, Joe and the Clinician both initially faked some stuttering in front of Mr. Du Pre, which seemed to embarrass him considerably. The rest of the time Joe talked to his father, he handled his speech using prolongations, except for one occasion when he had one of his old blocks, in which his eyes clouded over and he seemed immobilized. Arrangments were made for Joe's parents to come to Marquette the following week to see what Joe was doing in working on his speech.

Monday morning Joe read and spoke in monologue under DAF, progressing from .06 seconds delay to no delay with both earphones

on, then, still with no delay, to one earphone off, and finally to monologue with no delay and both earphones off. He was urged to attend to the "feel" of his speech and be his own judge as to when he was ready to move on to the next condition. He reported that he thought he had done well in the practice sequences but that he had been most fluent speaking under the delay condition.

In the other morning session, the focus of therapy was directed toward working with Joe on coarticulatory transitions in CVC utterances. They concentrated particularly on the continuants /s/ and /sh/ and the plosives /p/ and /b/. They mass-practiced word lists, words in sentences, and conversation, stressing proprioception, and with Joe faking easy ongoing dysfluencies on command. He then faked some more serious blocks and worked with the team member on coping with and tolerating the moment of tremor, slowing it down, and then coming out of it slowly, with strong positive movements. Joe was only partially able to do this last task – usually he came out too fast. Occasionally, Joe reported that he "felt his old self coming back," a return to his former stuttering pattern, and he was counseled to resist this temptation.

In Monday's videotaped session Joe shadowed some of his own audiotapes under different conditions in order to get "the feel" of fluency. Before, Joe had said that fluency didn't feel right, that it felt "strange." Joe was instructed to ignore "the hearing of it, but pay attention to the feeling of it." Joe had been recorded reading a passage, and he had a copy of the passage in front of him while he shadowed. At first, Joe whispered along with his tape recording, then he shadowed himself out loud, and finally the Clinician joined in, after instructing Joe to resist whatever the Clinician might say or do and just concentrate on the feeling of his words as he read aloud. As they read, the Clinician blocked on words as Joe was reading, rolled up a paper, and whispered in Joe's ear. Joe said that it didn't put any pressure on him.

After watching the videotape that afternoon, one of the Fellows asked Dr. Williams, the Consultant for that week, how he thought Joe should handle the fact that he was frightened by his fluency. Dr. Williams suggested that he learn what to do to "resist the block," because otherwise, superstitious behavior is given the credit for the fluency. As a procedure, he suggested having Joe concentrate on maintaining a rest position and being aware of it, so that when he begins to talk, he is aware of what he is doing. Dr. Williams also suggested that Joe needed more variation in speech – speeding up, slowing down, more animation, better inflection, and variety of pitch.

Joe's Clinician had noticed that Joe was fluent and relaxed

during informal sessions outside the clinic, but that he struggled when "working on his speech," in the clinic, so he conducted therapy during the next two afternoons in his home, arranging for people to pop in and out or stop by for extended conversations. The idea seemed to work – Joe was able to work on his speech under relaxed conditions, at least part of the time, and he seemed to be loosening up in the clinic as well.

Making use of the same principle, the team member who was with Joe in one of the morning sessions took him out on some assignments that were less contrived than usual. They did some shopping, accompanied by the team member's husband. Perhaps because of the husband's presence (Joe didn't know him very well and may also have considered him an authority figure), Joe was quite dysfluent. He used many starters (lip and tongue movements and "ums"), but he kept his speech forward-moving. Several times Joe failed to take advantage of a potential situation to work on his speech, which was inconsistent with his other recent behavior. A conversation with the team member's husband about a topic of mutual interest, however, led to a more relaxed atmosphere and a return to more fluent patterns of speech.

Joe arrived late Tuesday morning and didn't get an adequate explanation of the goals for the videotaped session. He was to interview Dr. Williams to find out what Dr. Williams meant by "moving forward and talking" and "getting the feeling of talking." Because Joe was ill-prepared, the session was less an interview than a therapy demonstration. Joe reported, however, that feeling what he was doing when he talked was important, and that some of Dr. Williams ideas fit in with Joe's use of prolongation.

After the session with Dr. Williams, Joe's team members prepared him for an interview with his former public school speech therapist, which was also videotaped. He was supposed to maintain communicative ease, not allow her to take charge of the session, and be assertive. He seemed to show a lot of avoidance behavior – broken words, starters, and word substitutions, and he may have been trying extra hard to be fluent for all the outsiders.

During the beginning of the interview he was very animated, and he spoke with more inflection than ever before. Unfortunately, however, the speech therapist was very authoritarian and gave Joe no opportunity to say anything, let alone take charge of the situation. Although she asked many questions, she seldom paused long enough to allow him to answer. When he would try to interrupt she kept on talking. Futhermore, she was unable to pursue the original topic of how Joe's speech had improved because she was busy defending her personal philosophy (probably for the benefit of the observers).

Interestingly, Joe assumed all responsibility for the failure of his therapy in high school. He said, "We talked about prolongations and repetitions, but I never really worked on it. And down here I am. I work on prolonging all the time."

That afternoon the Fellows watching the videotape wondered how Joe had reacted to this strange encounter. What had he said or done afterward? According to the team member, who was with him just after the taping, he had felt very positive and said that it made him feel proud to show his former speech therapist the improvement in his speech.

In the afternoon Joe talked with one of his team members about an address he was to give to a speech pathology class the next day. After considerable thought he decided just to say a few things and then answer questions. Although he did not want to say very much, he wanted some rehearsal, and he asked the team member to listen. His brief remarks concerned the emotions he had felt as a stutterer: feelings of being different, picked on, punished, slapped, misunderstood, etc. He talked also about how hopeless and worthless he used to feel, mentioning that he had considered suicide. Toward the end, however, he became very positive. He said that now there were things he was becoming able to do, that more things than just his speech were changing. And he wanted to keep on trying to improve himself. This was an extraordinary change in attitude from the depressed, dejected, person of three and a half weeks ago.

Later that afternoon, Joe had an interview with his Vocational Rehabilitation Counselor and afterwards talked to one of his team members about it. The Counselor had told him that it would not be possible for him to enter cooking school immediately, that he would have to stay where he was and then switch over later. To make matters worse, Joe would have to do remedial work in math in order to qualify. The Counselor also reported that from the eye test results, it looked as if Joe might need glasses. Joe was disappointed at all of this discouraging information and commented that his life had been filled with similar disappointments and that he had failed at just about everything he had ever tried. This was just another example of failure. But this time, he said, he would not give up. He really wanted to work on his multiplication and division, not because he cared about math, but because he had to do so to be successful. As for the glasses, he said he could probably adjust to them. He was disappointed, but motivated to overcome the difficulties. It was astounding, to anyone who had seen him at the beginning of the summer, how much hope he was expressing in the face of a substantial disappointment. Referring to how hard he had worked on his speech, he said, "If I can do 60 assignments in one afternoon, I can

learn math."

On Wednesday Joe spoke to a class in speech pathology. At first he was tense and his speech fragmented, but he warmed to the subject and talked for 22 minutes about his fears, his hopes, and his future. His eyes sparkled a bit and his determination was evident. Afterwards the Clinician said "If I have ever had any doubt about whether he would overcome, it was cast aside today." Joe took the rest of the day off.

On Thursday, Joe and his Clinician reviewed some of the things he had learned during the summer and prepared for the visit by Joe's parents later that morning. Joe identified nine topics or themes that had been covered during the summer.

1. Stuttering is holding back.
2. Avoiding just makes me talk worse.
3. If I get stuck I know what to do.
4. Talking is simply going ahead.
5. It's my mouth. I am my own therapist.
6. Stuttering is a silly way to talk. There is humor in it.
7. There is no point in rushing myself when talking.
8. I won't fall apart if I stutter. I can stand it.
9. I have earned the fluent stuttering I have.

Joe was happy that his mother was coming so that she could see what he was doing in the clinic. About his father he said, "Even though the old man won't change, maybe he'll stop hassling me."

In the videotaped session that morning, Joe's Clinician interviewed Mr. Du Pre. The Clinician began by trying to establish an open and honest relationship with him, but as the interview progressed, he concentrated on getting the father to admit some of his own responsibility in the poor relationship he had with his son. Mr. Du Pre, however, did not admit to anything, nor did he see any connection between Joe's stuttering and their relationship. Both Joe and his mother, who were watching the taping from the observation room, said that he was simply lying. Even when the Clinician probed hard ("I find it hard to believe you never let him know your disappointment"), the father admitted no part of it. The Clinician ended by telling Mr. Du Pre "Don't get in Joe's way. Get out of his way. Be supportive." The Clinician also made it clear that he knew the real story, that the father wasn't fooling anyone, but he never confronted him directly with this information, since he felt it would not serve Joe's best interest. Joe seemed to enjoy seeing his father on the hot seat.

A later discussion with Mrs. Du Pre made it evident that the relationship between father and son was even worse than had been suspected also provided some insight into Joe's hand tremors and

other signs of organicity. Before Joe's birth, Mrs. Du Pre had been working, and Mr. Du Pre had not wanted her to have a baby. The birth was difficult, and both mother and child were on the critical list for several days. Mr. Du Pre was informed but made no effort to see them or even inquire how they were. Also, when Joe was a teenager he had been in an automobile accident, and his father not only showed little interest in his recovery but told Mrs. Du Pre that he hoped Joe *didn't* recover. A different perspective on Mr. Du Pre developed, however, when it was further disclosed that he had been diagnosed as diabetic a few years earlier but refused any medical treatment and that he had a heart condition and had been counseled not to smoke or drink but continued to do so heavily. He did not seem to place a high value on his own life.

That afternoon, another team member, Mr. Du Pre, and Joe approached several outside speaking situations to give Joe a chance to "show his stuff" and to get the father to appreciate what Joe had been doing. There was some hope that they would be able to get Mr. Du Pre to stutter. Both Joe and the team member stuttered voluntarily when talking to a number of strangers – passers-by and store clerks. Mr. Du Pre was asked if he would try to stutter voluntarily in order to get the feel of what Joe had been doing. He rapidly changed the subject. In a final situation that developed unexpectedly – trying to get out of a parking ticket at the police station, the team member stuttered severely, and Mr. Du Pre pretended he didn't know them. The team member concluded at the end of the afternoon that there was no hope in trying to change Mr. Du Pre. It would be better to try and teach Joe to resist the hurts his father was capable of giving. In a discussion that evening with a few of his team members, Joe agreed that his father had not profited by the visit, but he thought his mother had. He also voiced some hope for the future "I know I can make it now that I know what I can do with my speech and I have the people to help me." Similar thoughts were voiced the next day when Joe viewed the first videotape he had made at the beginning of the summer: "I sure was sad, but I'm going to make it."

Allen Williams

The Clinician's goals for Monday's videotaped session were (1) to increase Allen's implementation of therapy for his short, rapid repetitions, (2) to increase his concern about short repetitions, and (3) to increase his awareness of the relationship between these repetitions and the need for fluency. Allen simply wanted to discover the presence and nature of his short rapid repetitions and to develop a therapy to reduce them.

The session began with a discussion about different kinds of dysfluencies. When Allen mentioned his concern over language formulation, the Clinician suggested that it might be normal to have fluency breakdowns because of a failure of language formulation. At this, Allen seemed to be a little confused, and the Clinician asked him simply to consider the various ways he could handle his therapy. Allen, however, had to decide first what direction he wanted his therapy to take. As a first decision, he thought it would be better to eliminate the cause of the dysfluencies rather than to cope with dysfluencies as they occurred, but he wasn't sure what the cause was. As the session progressed, Allen began to show more and more resistance to therapy. It was difficult, he said, to think through and come up with his own conclusions for the direction of therapy, and as soon as he had solved that problem he had to specify what the next problem was and then choose a therapy to solve it. He was tired of all the decision-making. When the Clinician suggested specifically that Allen try to find a therapy that would decrease the frequency of his short rapid repetitions, Allen said he couldn't find an answer that was suitable for him. He even became antagonistic, asking his Clinician why he should waste his time trying to figure out what the Clinician had programmed into him earlier. Eventually, Allen concluded that his therapy should be directed at trying to lower the need for fluency, which, he said, was right back where they had started.

After watching the videotape that afternoon, the Fellows felt that Allen's Clinician had not dealt with the resistance and negativity Allen had expressed. The Clinician, who happened to be present, said that since the negative feelings were not interfering with therapy there was no need to deal with them. Also, Allen had dealt with them himself. In the afternoon therapy session Allen was asked to evaluate his therapy needs for part-word repetitions. He said "I am in a set mood before I get into the repetition and I need to change this set." Pointing out that the set (which included the need to be fluent) could change very quickly, the Clinician reminded Allen that he would have to be able to monitor and evaluate the total communication set quickly. Allen agreed and then reported that he had heard a speaker on the radio whose native language was not English and he had analyzed his speech and found it very dysfluent. He asked if any research had been done on the occurrence of repetitions in learning a new language. He hoped there might be data relating directly to his own repetitions, which he thought were caused partly by difficulty formulating language. The Clinician pointed out some of the differences between different kinds of repetitions, and Allen replied "Okay, I guess that doesn't really have nothing to do with my therapy; let's get on."

In part of the morning therapy session, they had worked on Allen's low oral resonance and the hypernasal quality his voice acquired when he was using restricted articulatory movement as an avoidance behavior. Allen was asked if he could tolerate this additional procedure to his therapy. He felt that he could, and practice sessions were scheduled. The rest of the session was spent reading from a textbook for the purpose of practicing more "open" articulation with the aid of a mirror and two team members who signaled him by saying "What?" or "What did you say?" when he failed to use open articulation.

After the session, Allen suggested that he go on some outside assignments in order to practice his newly acquired skills of open articulation in conversational speech and to evaluate further his need to be fluent in outside situations. The suggestion was agreed to, and Allen and two team members left for the airport, where Allen had to make some arrangements for his ticket home. Since the arrangements were very complicated, the situation was difficult for Allen, but he had only two moments of difficulty. He did feel the need to be fluent, however, and the team member judged him to have been only about 50 per cent effective in completing the assignment of open articulation. Between situations Allen was practicing the jaw movements for more open articulation in a half joking manner. Remembering discussions among the Fellows that Allen may defuse anxious situations with humor, the team member suggested that he do the assignment seriously. Although he expressed some curiosity about this suggestion, Allen quickly stopped joking. He then carried out the same assignment in a second situation. This time, he was about 80 per cent effective, and he reported no need to be fluent. In a third situation, ordering in a restaurant, he had two moments of noticeable difficulty. While discussing his career goals over lunch with his team member, he had another serious dysfluency and reported feeling the need to be fluent. Again, he was about 80 per cent effective in completing his open articulation assignment. In the last situation, evaluating his afternoon, he was fluent, but his language, and perhaps his thoughts, about the afternoon were somewhat confused.

On Tuesday morning, Allen's Clinician presented three alternative therapy plans for the day. The first plan called for Allen to work on a 1½-2 minute speech for his public address class in which he would thank them for letting him participate. Allen rejected this plan, saying that the public address class no longer served a purpose for him. The second plan was to work, through assignments, on reducing the need to be fluent. When Allen said that he wanted to use this plan for the afternoon's activities, the Clinician reminded him that he must plan his assignments carefully so that they served a

purpose for him. The third plan was to discuss the influences Allen's parents had had on his stuttering and on his need to be fluent. Allen said that he wanted to spend the morning session talking about these areas, and the discussion immediately began.

Allen hadn't seen his mother in six years and had been considering the possibility of visiting her at the end of the summer. After a brief description of his decision-making process, but without making the decision, Allen changed the subject and began talking about his father. His father, he said, would expect him to be fluent when he came home – "He is expecting me to perform a miracle. He always expects that." But, Allen said, "I can deal with him and my stuttering at the same time." Allen's Clinician suggested that his father may feel guilty over Allen's stuttering, because Allen may have stuttered more during the time when his parents were having marital problems. It was a point of view Allen had never considered, but he did not comment on it. Although Allen seemed to get emotionally involved in this discussion he had only one block. The discussion began to ramble from the main topic, and the Clinician suggested that Allen start structuring his active therapy program for the rest of the day. After planning four assignments, Allen left with a team member to carry them out.

On the first assignment, Allen talked with the manager of a local clothing store, who, it was known, had once been a stutterer. With the intention of interviewing him about his stuttering, Allen found the manager and approached him directly, saying "I would like to talk to you about your stuttering." They talked for about 20 minutes, and the manager related some personal experiences that were similar to some that Allen had had. In the first part of the discussion, Allen had a number of dysfluencies. He was uncomfortable, and the stuttering was real, although he got control of it later. Afterward Allen felt that during the situation the need to be fluent had been strong. The team member suggested that Allen go back and talk to the man again to see if he could reduce the need to be fluent. The other three assignments were not carried out for lack of time.

Four goals were set for the videotaped session that morning: (1) talk with Dr. Williams, (2) make reservations by telephone for a dinner to be held for the Institute personnel the following evening, (3) experiment with his rate of speaking, still using more open articulation, and (4) desensitize himself further to the need for fluency. As the tape began, Allen made a statement which illustrated both his attitude and the improvement he had made in language formulation:

My goal is to talk fluently and put in some repetitions. At first I learned Van Riper's method – pull-outs and preparatory sets. My third week was to get rid of short repetitions I had without noticing them. We found out that the short repetitions were a noxious stimulus. So I went out and re- re- re- repeated. On Friday Sheehan and my Clinician told me I should fake some repetitions. When I did this, more involuntary repetitions were set off. Monday I gave a speech in class with lots of repetitions. Now we're working on that. My state of mind I need to deal with now.

When queried as to how he was dealing with it, he said that he had been going into situations. Dr. Williams asked him what was most important of what he had learned. He said "Learning what's going on when I stutter, but I need to get into more situations to see more what it is like, to learn how to control the feelings." During the last part of this session, Allen showed a fey sense of humor that had not been apparent in his personality before. For example, the following interchange took place during the taping while the team watched through the observation window:

Allen: What are my goals?

Dr. Williams: What do you mean by "experiment with rate," or "open oral articulation"?

Allen: I better start doing some repetitions – for the group. No, I better say for myself, or they'll get mad. No matter what I do they say "Do it for yourself."

Dr. Williams: Do you believe them?

Allen: Yes, They're right, but sometimes they think I don't realize it. So they explain again.

Dr. Williams: What do you mean by "rate"?

Allen: I can control what rate my breakdown will occur at. My Clinician will tell me again but I can't put it in his words, but I can put it in my thoughts. If you notice, speak slow, speed up, have a repetition, slow down. (*After a pause*) I guess we had better stop. I have to make a phone call.

Dr. Williams: I really enjoyed talking to you; you are doing well. Keep it up.

Allen: That's what they all say. I need being pushed. I get satisfaction from my own past. It makes me feel good, but there is a limit.

Dr. Williams: Are you uncomfortable being pushed?

Allen: Sometimes. But I need more of it. Hear that, team?

Several minutes later, Allen made some phone calls from the secretary's phone. There were two video cameras and a dozen people watching. He seemed to enjoy this situation of playing to the audience.

On Wednesday, Allen, his Clinician, and the entire team went to a nearby health camp, where Allen thought he would be able to create some stressful situations by talking to other stutterers and their clinicians. The goal was to keep the need for fluency at a low level. On the way Allen seemed subdued, and he reported later that he had felt depressed because he thought his Clinician wanted him to be fluent for the next two days so that he could get some videotapes demonstrating his progress. The Clinician assured him that this was not true and that he could do whatever he wanted during the next few days.

At the health camp, Allen visited the group therapy session. While there, he told the clinicians that he thought they were doing the wrong thing in asking stutterers to explain what they did when they stuttered; he, for one, found it frustrating because he could not answer the question. His speech was fluent in this situation.

When they returned to Marquette, Allen said that he would like to turn the tables by sitting in the observation room and watching his team while they were on videotape. The team agreed, but since it was late they broke for lunch before taping. Allen was late returning, and the team didn't know whether Allen was watching them until the taping was over. After the taping, Allen and the team talked for a while, and then everyone started to go home. Allen started to leave and then turned in the doorway and said "I forgot to give you your reward" and handed out a little package of M & M's to each team member.

That afternoon, Allen decided that he wanted to go downtown. It wasn't clear whether he wanted to work on specific assignments or just relax, but two team members accompanied him. The three of them engaged in occasional horse play between some assignments that Allen handled extremely well. Although the afternoon was unstructured in that no goals or procedures were predetermined, Allen took every opportunity to practice his speech. In a relaxed moment, Allen and the team members exchanged addresses and some personal information. It was one of the few times Allen had said anything about his personal life. As one of the team members noted, it was the first time Allen had reached out to them so naturally and so comfortably. In his report the team member wrote:

> This was the most successful afternoon, insofar as situational therapy is concerned, that he has had since he has been here. [The Clinician found next day that Allen agreed.] It is significant that Allen's need for fluency was so low and his speech contained so few dysfluencies that neither team member attended to it during the whole afternoon. It was all cheerful, friendly, and natural.

In retrospect, this afternoon of activity that Allen and the team

members enjoyed so much was probably not really "successful" in terms of Allen's therapy. Certainly, the team members and Allen became more intimate with each other – some of the invisible social barriers that keep people from communicating directly with one another fell, and everyone felt friendlier and more relaxed. But the ease with which Allen carried out his assignments, his low need for fluency, and his good speech are hardly surprising under such conditions. Of course, the establishment of friendship with a client, or any other basis on which unfettered communication can take place, is an important step in the beginning of therapy, and if this had been the beginning of Allen's therapy the afternoon would undoubtedly have been "successful." Unfortunately, Allen was going home in a few days. It is perhaps wise, and not cynical, to be skeptical of reported "success" on a situational assignment when other elements in the report suggest that the stressfulness or difficulty of the situation was diminished and when the success is measured by fluency. Fluency alone is never a sufficient measure of clinical success; it must be fluency that is more than just temporary, achieved without the use of avoidance behaviors, and in a situation where fluency would not have been expected before therapy.

On Thursday, Allen decided that he did not want to have any therapeutic acitivity, and he was not in attendance during the whole day. This absence may have been a kind of test of his Clinician's sincerity in saying that he could spend the next few days doing anything he wanted. With only one day of therapy to go, it was much too late for Allen to be doubting his Clinician's sincerity, if that's what it was. Perhaps he didn't feel the need for therapy any more.

On Friday, Allen and a team member went downtown to pick up a gift for his Clinician. Using an old assignment, he asked to talk to the manager, demanding a three per cent discount because he was going to pay cash. As he followed the clerk back to the manager's office, he looked back at the team member with a huge grin. He came back with the discount, which added a fitting touch to the gift.

Robert Roth

In the first morning therapy session on Monday, the team member asked Bob to talk about the situations and the people that will create difficulty for him when he first gets home. Bob was to visualize what would happen during the first three days he was home and explain how he intended to handle whatever situations would arise. Bob said first that he was afraid of leaving *this* atmosphere and entering *that* atmosphere and that he would get more anxious as the

airplane descended toward New York. He thought he would prepare himself for the ordeal of meeting friends or relatives at the airport by talking to other people on the plane while faking stuttering and monitoring his speech. As soon as he got off the plane, he thought he should fake a block immediately, preferably on the first word. This would allay the expectation of fluency that his family and friends would have. After he had made it clear to all that he was not fluent, perhaps he could afford to reduce faking and depend primarily on scanning and monitoring. Monitoring, he thought, would be his primary way of preventing a return to his old stuttering pattern. Faking would be particularly difficult because he can't let anyone else know he isn't actually blocking. If he once let them know he was faking, the purpose of faking would not be served. He also said that he would have to go on faking occasionally, even after the initial period of being home was over. According to this interview Bob had achieved almost completely the goals that were set for his therapy at the beginning of the summer, at least as far as his attitude toward stuttering was concerned. Although Bob had been superficial in his conceptualizations before, in this session he was able to use his new perceptions and his new techniques creatively for the first time.

During the last week, Bob's Clinician wanted him to continue learning how to resist his old blocks, and how to move out of them. To accomplish this, he would go on observing his old blocks from the Kalamazoo videotape. The Clinician also thought Bob needed more practice slowing down the tremor because he had recently seen Bob recoiling and substituting words. He thought Bob also needed to learn how to use preparatory sets himself, without coaching. The immediate goal for the videotaped session that morning was to see if Bob could predict his blocks and change their form.

During the taping, Bob and the Clinician talked about the return to New York. Since Bob seemed to be monitoring every word, it was not possible to tell whether the original assignment was carried out. Futhermore, he was bored and uninvolved so that nothing very interesting took place.

In the other morning therapy session, Bob watched his videotape from Kalamazoo again, paying particular attention to his lip tremors. He was also told to repeat any word he had stuttered on the tape as many times as he could during the elapsed time of the taped block. Other tasks were imitating himself and trying to predict the moments of stuttering on the tape. Then the tape was run, and Bob carried out the assignments without difficulty. Afterwards, the Clinician asked "How did you feel, watching the videotape; did you feel any fear?" "No," Bob said, "just fear of going home. Is that what you mean?" Pressing Bob for better understanding, the Clini-

cian asked "Are you afraid of going home or of not being able to maintain something?" Bob replied "I'm afraid of not being able to maintain fluency." After a pause to let the point sink in, the Clinician, trying to assist Bob in specifying the source of this fear, asked "What about your friends at home? Will they give you trouble? How do you feel about them?" Bob said "Not good. I told them I might come back fluent." "You set yourself up," the Clinician said, and Bob ruefully agreed "Yeah, I know." They both realized from this information that the return home might be even more difficult than they had thought.

That afternoon, Bob went out on assignments. He was supposed to find speakers who were either very rapid or very slow in rate and resist competing with them. This assignment followed from an earlier discussion of Bob's rate of speech, which was quite rapid. He found his first speaker at the office of the local newspaper and commented that she spoke at normal speed, but added that "I speeded up too much in talking to her – why do I always do that?" At a store, Bob approached a male clerk and asked him a number of questions about a product. He made sure some of the questions were absurd because he was trying to get the clerk angry, hoping that anger would make him speed up his speech, but the clerk's speech rate didn't change. Bob went on to encounter several other speakers, none of whom had an unusual rate. Finally, he gave up the original assignment.

Over a cup of coffee with the team member, Bob talked again about how anxious he was over the return home. As Bob's confidence in his ability to handle this impending problem weakened he tended to place the blame on others for the failures he anticipated. Consequently, he began to derogate some of the therapy he had received. He said that he considered monitoring another "trick," and that its usefulness was weakening. (It should be recalled that the preceding Thursday he had said that without monitoring, "he was dead.") He elaborated on his feeling that he didn't know how to deal with his speech, that he was beginning to substitute words and was concerned about it. The team member counseled him about what steps he could take to deal with the problem, but in answering he had two very brief pauses and called attention to them, saying that he "had failed." Bob's crisis of confidence seemed similar to, although less severe than, the one Joe had had in the first few days of the Institute. By pulling Joe out of his crisis, a forward momentum had been established which seemed to have been a great aid in therapy. If this could be done for Bob, the same effect might facilitate his return home. The difficulty was that Bob's crisis deepened, or at least his fear increased, as the time approached for the Institute to terminate.

Although it was clear that a crisis was developing, it was not immediately apparent how serious it would be nor what the dynamics of it would be, so, for a while, Bob was given his own lead while the team observed. In the first session Tuesday morning Bob was told to talk about anything except speech. After some superficial conversation, Bob was asked what he thought about himself, and he listed a number of characteristics. The first one he named was honesty, which may have reflected the discussions of the preceding week. The rest of the characteristics formed a pattern: sensitivity, helpfulness, thoughtfulness, friendliness, courtesy, and kindness. When asked how people demonstrated that they cared about others he said that they did so by doing things for others, but he commented "I must have read that somewhere." He also said that people showed their affection by "playing or fooling around." This last idea was certainly not something Bob had read. When asked to identify five people who cared for him, he readily named five members of his family, but then dismissed his answer because "they are all relatives." He then identified five others who cared for him, and only one was someone from home; the others were members of the Institute.

Bob then worked for an hour by himself planning for the videotape. When the time came to make the tape, the room was locked, and his Clinician was not around. Bob left to find a key. He had to ask directions first to get to an office where the key was, but, since the directions were apparently wrong, he couldn't find it. After calling and whistling to a group of students to get their attention, he was getting new directions when he spotted a man with a large key ring, and asked him to come and open the door, which he did. The team member, who watched all this, was surprised at his initiative, his responsible manner, and his lack of comment or approval-seeking. He was completely straightforward and businesslike.

That morning, the videotaped session was conceived and controlled entirely by Bob. He took the first few minutes to make a statement and then asked that each member of his team, and Dr. Williams, question him about it afterwards. In his opening statement, he criticized the Institute because, he said, the Clinicians had been unable to help him very much during the first week since they didn't know him very well, and he suggested that the Institute should have been one week longer. He made some other criticisms which were similarly superficial. He then spoke at length about how much he needed confidence and said that if the team had been more familiar with him from the beginning they would have been better able to fulfill his needs. Repeating a theme from the first week, he suggested that the Institute had been designed more for the sake of learning

than to help him.

After watching the videotape that afternoon the Fellows were uncertain what had motivated Bob to handle the taped session the way he had. In trying to find an answer to this question the discussion turned to a number of observations the Fellows had made of Bob's behavior during the past few days. First, several Fellows had observed that Bob had begun to use obscenity in his speech with them, which he had not done before, and they felt that it meant that he was continuing to become more relaxed, friendly, and open. He had done something else, however, which was more unusual. He had taken several team members individually into his confidence, swearing them to secrecy, and discussed some personal matters with them. Although none of the confidences had been broken, the Fellows thought it odd that he had these confidences with so many individuals but was unwilling to share them with the group. There may have been one or two team members whom Bob did not yet completely trust.

At the beginning of the first afternoon session Bob said he felt depressed and didn't want to go out on assignments. With a little coaxing, however, he went out, but without enthusiasm. In the first assignment he talked with a woman clerk at great length, resisting the temptation to run from stuttering moments by slowing down and deliberately using slow movements through the words. At no time in this experience did he stutter without doing something about it. At a gas station, an unplanned situation developed when Bob had to interrupt the attendant to get served, but he did so without difficulty. At the bank he had a twenty-minute discussion with a teller. Occasionally, he blocked, but he handled each one appropriately. Bob then went to the parcel-delivery service where he had to file a claim for a missing parcel. He had to go through his explanation twice, and he did have a few blocks, but he worked his way through them. At the end of the session the team member noted that "Bob's situations must be real and not contrived if they are to have meaning for him. He must lose himself in the activity, and if he is then able to handle his speech when the genuine need arises, he knows that he has accomplished something meaningful."

Because Bob had repeatedly expressed concern about returning home it was decided that systematic desensitization would be done to reduce this fear during the last four days of the Institute. In the first session the team member explained to Bob what the process of systematic desensitization was about. He then asked Bob to prepare a specific list or hierarchy of the situations he expected to face on his return home, arranged on the basis of chronology. The rest of the session was spent introducing Bob to the GSR (galvanic skin

response) unit, which was to be used as a measure of anxiety.

During lunch with one of his team members Bob said again that he was concerned about his lack of confidence. The team member counseled him that real confidence was knowing that you could fail and try again, knowing what you *couldn't* do and accepting it, or feeling confident even when you fail in some respects. Bob seemed to accept this but said that he needed more speaking situations, since "I won't have any more after this week." The team member acted surprised at this comment, saying that he would have them all his life – he would always have the opportunity to talk – and he seemed to think this was a good idea.

On Wednesday, Bob continued his program of systematic desensitization, although he was still in the preliminary stages. During the first part of the session, Bob was trained in relaxation. First, the team member asked Bob to imagine relaxing scenes while attending to the state of his muscle tonus. As the session progressed, Bob's team member trained him specifically in the visualization of scenes by asking him to imagine a scene and then asking him questions about details from it. Training, both in visualization and in relaxation was highly successful.

Later that afternoon, the team member trained Bob in recognizing and reporting anxiety by having him imagine scenes in which some inherently fearful stimuli were introduced and asking him to take note of the feelings he had at the time of their introduction. Bob seemed to learn to identify anxiety without difficulty.

On Thursday morning, Bob was put through a series of relaxation exercises. The goals for this session were to desensitize him to the anxieties of returning home, specifically those related to his speech and his stuttering. Although anxiety was measured by a GSR apparatus, Bob was also asked to raise his finger if he felt anxious. A number of scenes were presented from the hierarchy that had been worked out previously: getting off the plane, meeting relatives, walking into his house, meeting his friends, faking stuttering, having bad blocks, having easy blocks, etc. None of these scenes produced a reaction except meeting relatives. When this response occurred, as noted on the GSR, Bob was instructed to stop thinking about the scene and to relax, after which the scene was presented again. There was no reaction on the second presentation.

In a second session that morning, Bob was again placed in a state of relaxation. This time, the events leading to his return home were presented sequentially: waking up in the morning on the last day, packing, driving to the airport, taking off, landing, debarking, meeting relatives, driving home, going into the apartment, first conversation with friends, etc. GSR reactions occurred on: having

lunch on the last day, waiting for his Clinician to drive him to the airport, packing, being at the airport, hearing the approach to La Guardia announced in flight, landing in New York, leaving the plane, seeing a relative, and being in the car approaching his house. Each time that there was a deflection of the GSR needle, Bob was told to stop imagining the scene and relax. When the needle returned to a low level, the scene was reintroduced until there was no more reaction. Afterward, Bob seemed relaxed and comfortable.

That afternoon, relaxation was once again induced, and a series of scenes were presented, again in the order Bob would experience them on the last day of the Institute. The same procedure as in previous sessions was followed. At the end, the team member recommended that Bob practice back in the trailer visualizing these scenes while in a state of relaxation. This session was videotaped, and the Fellows viewed it later that afternoon. They commented on how skillful Bob was in doing some of the tasks that were required – visualization and relaxation – and it was noted that such skill was consistent with his general suggestibility. A question was raised about the distinction between systematic desensitization and post-hypnotic suggestion. Two distinctions were pointed out: First, in post-hypnotic suggestion, a clinician would simply place the client in a hypnotic state and tell him that when he awoke he would be fluent. In systematic desensitization he actually experiences feared scenes while in a state of relaxation. This procedure reconditions his emotional reactions from anxiety to relaxation. The other distinction involved the degree to which the client participates. If nothing but suggestion were being used, the scene would have been described for Bob in detail and he would have had the more passive role of visualizing it. Instead, Bob composed the scene himself, creating most of the details. He was doing more than just following suggestive instructions.

On Friday, Bob had lunch with his team at a local restaurant. They presented him with a harmonica (he had indicated an interest in learning how to play one) engraved with each of the team members' names. It was an extremely touching moment, and Bob wasn't the only one who was under emotional strain. He had several real moments of stuttering but pulled out of them well, even when making a number of direct statements about his emotions. Then his speech cleared up and he was fluent for the rest of the day. Later that afternoon, a team member took Bob to the airport. As he boarded the plane, there was a soldier on crutches who was also boarding. Bob helped him onto the plane, talking to him as he did so. As the team member noted, "He left talking."

EPILOGUE

by Malcolm Fraser

The future of these stutterers is still to be written. During the four weeks of actual therapy they improved markedly in many ways. And although we will hope that they will be in the classification of corrected stutterers, unfortunately no one can predict the permanence of a stutterer's progress toward fluency.

From a survey report made after their return home, we do know that the Clinical Fellows feel that their experience at the Institute will have a great impact on their work with stutterers and in their training of future clinicians.

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